New Cross Health Centre

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.

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Overall summary

New Cross Health Centre provides NHS primary care services to patients in the New Cross area of Lewisham in London. The practice currently has approximately 6000 patients on its list. The practie is registered with the Care Quality Commission to provide the following regulated activities: diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures and treatment of disease, disorder or injury.

We carried out an announced inspection of the service on 14 July 2014. The team, led by a CQC inspector, included a GP, a former practice manager and a second CQC inspector. We spoke with six patients attending the practice on the day of the inspection and collected 28 comment cards which patients had completed about the service in the days running up to the inspection.

The practice had systems in place to manage risks associated with infection control, medicines management, staff recruitment, child protection and medical emergencies. However staff refresher training on adult safeguarding was out-of-date. There were mechanisms to investigate and learn from incidents and complaints.

Patients told us the service was caring. Most patients we spoke with were happy with the service they received at the practice although some patients said it was difficult to see the same doctor and this negatively affected their experience. These findings were echoed in the 2014 national GP patient survey. The practice benefitted from a Patient Participation Group and acted on patient feedback and complaints. Members of the patient participation group were not representative of the wider practice population.

The practice was able to demonstrate an understanding and awareness of the needs of the local population including students, people with enduring mental health needs, frail older people and people in vulnerable circumstances. The practice provided a number of services tailored to particular patient groups and provided additional services for its student population. There was good collaborative working between the practice and other health and social services. The practice had recently implemented an innovative online telehealth system to improve patient access to health information and advice.

There were arrangements in place to monitor quality and patient outcomes and the practice had recently focused on improving child immunisation and cervical screening uptake with success. The practice participated in clinical audits required to meet contractual targets, revalidation and appraisal requirements and external peer group meetings. However, the practice was otherwise making little use of clinical audit to drive improvements in clinical care.

Staff were recruited safely but the practice had been relying heavily on locum doctors to cover a high proportion of clinical sessions for several months following the departure of the lead GP. This had affected patients' experience of continuity of care. It had also limited the doctors' access to clinical leadership and support over the same period. At the time of the inspection, the risk was being addressed by using a smaller group of regular locums and the practice had recruited a lead GP who was due to start later in the Summer.

There were governance structures in place and an open reporting culture. The GP partners were located at a different site and, although responsive to staff concerns, were not proactively identifying and managing risks in the absence of a GP lead at the practice. Some aspects of governance and oversight needed improvement. We found that monitoring procedures were in place but not always fully carried out, for example daily fridge temperature checks were incomplete and out of date sterile dressings had not been disposed of. The practice had not formally notified the Care Quality Commission of changes to its partnership arrangements as required.

The provider was in breach of regulations related to:

- Safeguarding people from abuse
- Cleanliness and infection control
- Assessing and monitoring the quality of care

Summary of findings

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.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Staff were recruited safely but the practice had been heavily relying on locum doctors to cover a high proportion of clinical sessions for several months. This had affected patients' experience of continuity of care and increased the risk of poor care. At the time of the inspection, the risk was being addressed by using a smaller group of regular locums and the practice had recruited a lead GP who was due to start later in the Summer.

The practice learned from incidents to improve the safety of the service. Incident reports were reviewed by the practice partners who provided feedback to staff and changes were made to the service if appropriate. The Hurley Clinic Partnership also produced a clinical governance newsletter sharing learning across all practices in the group. However staff could not recall seeing this newsletter which limited its effectiveness as a learning tool. Staff were aware of how to report concerns within the practice to protect children and vulnerable adults from the risk of abuse. However staff refresher training on adult safeguarding was out-of-date and some staff were vague about wider safeguarding procedures locally. Staff were trained to respond to medical emergencies.

The practice was clean and there were systems in place to reduce the risk and spread of health acquired infection although a few items of furniture needed repair or replacement. Medicines were managed safely with checks made on repeat prescribing and the stock of medicines. However the security of prescriptions needed improvement.

The practice was well-equipped and generally well-maintained however although monitoring procedures were in place, they were not always fully implemented. For example, we found occasional gaps in the temperature checks of the medicines fridge and some dressings which were past their expiry date.

Are services effective?

Patients' needs were suitably assessed and care and treatment was delivered in line with current legislation and guidelines. There were arrangements in place to monitor performance and patient outcomes and the practice had increased child immunisation and cervical screening uptake.

The practice participated in clinical audits required to meet contractual targets, revalidation and appraisal requirements and

Summary of findings

external peer group meetings. However, the practice was otherwise making little use of clinical audit to drive improvements in clinical care. The practice reviewed and reported on its performance on a range of measures including patient experience on a monthly basis.

There were arrangements in place to support staff appraisal, learning and professional development although we were told that clinical support and mentorship for the doctors had been more limited in recent months due to the departure of the lead GP.

The practice worked in collaboration with other health and social care professionals, for example to provide integrated patient care to patients with complex needs.

The practice provided patients with advice and guidance about health promotion and illness prevention, for example offering health checks to all newly registering patients. The practice participated in national population screening and immunisation programmes. The practice had recently introduced an innovative telehealth service for its patients which included information and online access to a pharmacist, nurse or their own GP.

Are services caring?

Most patients we spoke with or who completed comment cards were positive about the service and praised individual members of staff. These findings were echoed in the practice's own patient surveys and the 2014 national GP patient survey which found that 83% of respondents would recommend the practice.

Several patients commented that staff treated them with dignity and respect and they felt involved in their care. We observed patients being welcomed in a friendly and polite manner when they arrived at the practice. The arrangements for ensuring patient privacy and confidentiality were effective.

Patients were asked for their consent and staff acted in accordance with their wishes. The practice had a Patient Participation Group which met regularly and had influenced the service.

Are services responsive to people's needs?

The practice was able to demonstrate an understanding and awareness of the needs of the local population including students, people with enduring mental health needs, frail older people and people in vulnerable circumstances. The practice provided a number of services tailored to particular patient groups by participating in "local enhanced schemes" and provided additional services for its student population. There was good collaborative working between the practice and other health and social care services which helped to ensure patients' needs were met.

Summary of findings

Patients were able to access appointments when they needed them although patients told us they had difficulty seeing the same doctor and this was echoed in the 2014 national GP patient survey findings. This situation had been exacerbated by a number of doctors leaving and the use of locum staff. Patients requiring specialist investigation or treatment were able to use the "Choose and Book" scheme to book a convenient first appointment. The doctors followed-up vulnerable patients following referral and discharge from specialist care.

The practice learned from patients' experiences, concerns and complaints to improve the quality of care.

Are services well-led?

The practice had been through a period of transition with GPs joining and leaving the service over the previous year. There had been a lack of effective clinical leadership while the lead GP post was vacant. The GP partners were located at a different site and, although responsive to staff concerns, were not proactively identifying and managing risks, such as the heavy use of locum staff to cover vacancies, during this period.

There were governance structures in place and an open reporting culture. Staff were encouraged to learn from incidents and individual clinical staff members were auditing aspects of their practice. However it was unclear how the practice used audit more generally as a driver for improvement. Some aspects of governance and oversight needed improvement. We found that monitoring procedures were not always fully carried out and the practice had not formally notified the Care Quality Commission of changes to the partnership.

Practice performance was tracked on a range of standardised measures which included patient feedback, patient outcome measures provided by the clinical commissioning group and QOF achievement.

The practice had a Patient Participation Group. The group had helped to design the practice patient survey and had identified a number of issues which affected patients. However the group was not representative of the wider practice population as, for example, there were no student members at the time of the inspection.

Staff met regularly to discuss and reflect on the service. There was an open reporting and learning culture in relation to incidents. We were not able to access audit records during the inspection and so did not see whether or how the practice systematically used audit to improve care.

Summary of findings

The practice did not keep a risk register. Although some risks, such as proportion of sessions covered by locum staff had been mitigated, the practice did not appear to be proactively managing risk effectively in the absence of a lead GP.

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
There were effective arrangements to identify vulnerable and frail older patients at risk of abuse. Care and treatment was planned with appropriate reviews to meet the identified needs of patients over the age of 75. There were arrangements in place for engagement with other health and social care providers.

People with long-term conditions
The practice cared effectively for people with long term conditions. It was performing in line with national and local targets for a range of conditions and had plans to improve the range of therapies provided for patients with diabetes. Clinical staff were made aware of alerts about relevant guidelines. The practice operated a 'case management' system for patients with complex needs.

Mothers, babies, children and young people
The practice offered a range of services for mothers and babies and was improving its performance against national targets in relation to primary care services for children. Staff understood their responsibilities in relation to safeguarding children and acted when they had concerns.

The working-age population and those recently retired
The majority of patients using the service were of working age. Patients generally reported having good access to services and the practice had expanded the range of ways for patients to access the service online and at a time convenient to them. The practice had worked with the university to meet the needs of students.

People in vulnerable circumstances who may have poor access to primary care
The practice ensured primary care services were available to people in vulnerable circumstances.

People experiencing poor mental health
The practice had effective arrangements for monitoring and reviewing patients in this population group, including their medicines. The practice facilitated and encouraged access to mental health support and counselling services.

Summary of findings

What people who use the service say

We reviewed the most recent national patient survey results for this practice; information published on the NHS Choices website and the practice's own patient feedback surveys which were carried out every quarter with a longer survey carried out annually. We also obtained evidence from interviews and comments we obtained from patients during the inspection.

Most patients we spoke with were happy with the service they received at the practice and commented positively on the doctors in particular. They said they were fully involved in decisions about their treatment and did not usually feel rushed. Patients said the premises were clean and well laid out. The results of the 2013 national patient survey for the practice showed that 75% of responding patients would recommend the practice to others.

Patients were more critical of the difficulties in seeing the same doctor over time. We spoke with some patients who said it was important to see a doctor who was familiar with them and their condition. These patients said the recent departure of several doctors at the practice had a negative impact on their experience of primary care. The patient participation group representative we spoke with and recent comments from patients on the NHS Choices website echoed these concerns.

Areas for improvement

Action the service MUST take to improve

- There had been a lack of effective clinical leadership while the lead-GP post was vacant
- Staff training on safeguarding vulnerable adults was out of date for some members of staff
- Fridge temperature checks were occasionally not recorded every day although this was practice policy
- Some sterile dressings had not been disposed of by their date of expiry.
- Some chairs and one of the examination couches were in need of replacement or repair.
- The security of prescription forms was not robust
- The practice had not formally notified the Care Quality Commission of changes to its partnership arrangements and the absence of its registered manager
- The practice was making limited use of clinical audit to drive quality improvement

Action the service SHOULD take to improve

- The practice patient participation group was not representative of the wider practice population
- The practice did not ensure that staff members had access to the clinical governance newsletter
- The practice had little information in the waiting room tailored to the student population

Outstanding practice

Our inspection team highlighted the following areas of good practice:

- The practice provided services to a young, mobile and sexually active population. All newly registering patients were offered HIV screening and vaccination for Hepatitis B as a matter of course, with rapid access to specialist services, including mental health services, if required. The practice actively promoted self-testing kits for chlamydia.
- The practice had recently started offering an online telehealth service provided through the Hurley Clinical Partnership. This allowed patients to contact the practice via an interactive webform. The system incorporated safety checks and had the potential to reduce unnecessary consultations.

New Cross Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and the team included a GP, a practice manager and a second CQC inspector. The GP and practice manager were granted the same authority to enter New Cross Health Centre as the CQC inspectors.

Background to New Cross Health Centre

New Cross Health Centre provides NHS primary medical services to approximately 6000 patients in the New Cross area of Lewisham in London. The service is provided from a single, modern site which is accessible to people with disabilities.

Over half the patients registered with the practice are students attending nearby Goldsmiths University. The local ward is characterised by relatively high levels of deprivation with higher than average rates of unemployment. The population of New Cross is relatively young and culturally and ethnically diverse.

Appointments are currently available morning and afternoon between 8.30am and 6.00pm four days a week with extended evening hours each Tuesday. Appointments can be booked online. There is an electronic prescription service and the practice has recently started operating an online telehealth service for patients. This enables registered patients to obtain advice, information and consult with their GP via a structured interactive web form.

The practice does not provide a service out of hours. Out of hours primary care is accessible through a nearby GP walk-in centre, SELDOC (South East London Doctors' Co-operative) and Lewisham Urgent Care Centre.

Two new GP partners joined the practice in 2013. The practice partners were not routinely undertaking clinical sessions at the practice themselves. Instead, they employed a number of sessional GPs to provide the service to patients. At the time of the inspection, the practice employed two part-time GPs and a part-time practice nurse. There were a number of additional clinical staff vacancies which were being covered by locum staff. The practice had a salaried "lead GP" post which was vacant.

The practice is managed as part of the Hurley Clinical Partnership, a GP partnership with over twenty practices located across London, and utilises this group's centralised governance and support functions.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We liaised with Lewisham

Clinical Commissioning Group, NHS England, Healthwatch Lewisham and the local authority. We also obtained feedback from a supported living scheme for older people and Goldsmiths University both of which were located close to the practice.

We carried out an announced visit on 14 July 2014. During our visit we spoke with a range of staff including a GP, the practice manager, two regional managers, reception staff, the locum practice nurse and the health care assistant. We also conducted telephone interviews after the visit with the practice nurse and another GP. We spoke with six patients who used the service and one member of the practice's patient participation group. We reviewed comments cards left by 28 patients sharing their views and experiences of the service.

We observed how people were greeted during our visit and viewed the premises, emergency equipment, medicines storage and locum packs. We reviewed information that had been provided to us at the inspection and we requested additional information which was reviewed after the visit. Information reviewed included practice policies and procedures, complaints and incidents, the staff training matrix, written confirmation of recruitment checks, the clinical governance newsletter, performance monitoring information and health information and advice leaflets.

Are services safe?

Our findings

Safe patient care

The practice had procedures in place to report and review incidents, raise any safeguarding concerns and ensure safe patient care was maintained.

Incidents and complaints were escalated for review and feedback. Safeguarding procedures were directed to the practice manager for escalation as appropriate. The number of recent incidents and serious untoward events at the practice had been low but when incidents had occurred they had been reported promptly and reviewed.

The practice manager forwarded safety alerts and any updates to national and local guidelines or policy to the relevant team members. The premises were well maintained and suitable for the purpose of providing diagnostic examination and medical treatments.

Learning from incidents

Significant events and incidents were reported on a standardised form and sent to one of the practice partners via secure intranet. These incident forms were reviewed by a committee of the Hurley Group Clinc Partnership including one of the GP partners of New Cross Health Centre. The outcome including any learning or action points was emailed to the relevant practice staff. The practice could show that it had responded to feedback and made improvements. Analysis and learning points from events and incidents were also shared across the wider group of Hurley Clinic Partnership practices by email and a clinical governance newsletter.

The salaried GPs at the practice met with the practice manager each month and told us they also reviewed incidents and feedback at these meetings although these meetings were relatively informal and not minuted. Staff confirmed they received email feedback about incidents and said they found this helpful. But clinical staff were unaware of the clinical governance newsletter and a copy of this could not be located in the practice on the day of the inspection. The newsletter was not being used effectively.

The practice had recently experienced a serious untoward incident on the premises involving a person who had harmed themself. The staff acted quickly to protect the health and privacy of this person who was not a registered patient. This incident was reported and reviewed for learning and the staff had been praised for their actions.

Staff members told us the incident had been stressful but they had worked well together as a team and followed emergency procedures effectively. Learning points included collecting more detailed information about people who were not registered patients if possible before they attended the practice.

Safeguarding

The practice had child protection and safeguarding vulnerable adults policies. Summarised information about the child protection process was displayed on the walls of the consultation and treatment rooms for ease of reference. Staff told us they would report any concerns to the practice manager for escalation but some staff members were vague about what would happen after that. The practice manager was the current practice lead for child protection and safeguarding and was aware of local contacts for social services, the police and community health teams. Children known to be at risk were flagged on the practice medical records system so staff were alerted when they attended the practice.

Staff were able to give us examples of how they had acted on concerns. For example reception staff became worried about a child in the waiting room and raised a concern. A GP gave us an example of raising a concern about a vulnerable older patient's lack of access to podiatry earlier that day. Staff understood they had an obligation to report safeguarding concerns without delay.

Practice policy was that all staff were trained on child protection at least to Level 1 while doctors were trained to Level 3 with periodic refresher training. We reviewed the practice training matrix which showed that some clinical staff members' training on adult safeguarding was out of date. The practice manager had been recently appointed and was aware of the situation but had not yet been able to find suitable refresher training opportunities for adult safeguarding.

Monitoring safety and responding to risk

Staff understood the risks associated with the provision of primary care services. The practice had policies covering the management of medicines, infection control, safeguarding vulnerable adults and child protection, health and safety, information security and repeat prescribing. There was a business continuity plan and a health and safety risk assessment for the premises.

Are services safe?

The practice nurse and health care assistant were responsible for carrying out routine checks on the premises, equipment and stock on a day to day basis including emergency medicines and equipment, daily checks of the fridge temperatures and vaccines. Monitoring checks were recorded and these records were readily available for inspection.

Medicines management

The practice had a policy for repeat prescribing. All repeat prescription requests were reviewed by a salaried doctor rather than locum members of staff. Staff told us that prescriptions were processed within 48 hours. Requests for repeat prescriptions were not accepted over the telephone. Any unusual or unsafe requests, for example for large quantities of a medicine were followed-up by the reviewing GP and alternative options discussed with the patient.

We were told that patients who had been prescribed medicines which required a greater level of monitoring, such as mood stabilisers, were regularly reviewed and received health checks in line with relevant guidelines.

The practice had procedures to ensure that the correct temperature was maintained for the storage of temperature-critical medicines. There was a process for staff to follow should the fridge temperature deviate from the accepted range and put the integrity of stored vaccines at risk. The fridge temperatures were usually checked daily by the practice nurse or health care assistant, or if they were out, by the reception staff. However, we saw that on two occasions within the last three months these checks had not been recorded. We also saw that the emergency drugs were in date and were being routinely checked.

Prescriptions were stored securely. However, the practice did not have effective checks in place in relation to prescription forms, for example, staff told us they would not be able to easily check if prescription forms had gone missing because they did not keep a separate record of serial numbers.

Cleanliness and infection control

The practice nurse was the named infection control lead. Patients told us the practice was clean and they did not have concerns about hygiene. The practice generally appeared clean and well organised on the day of the inspection. All the treatment and consulting rooms were well equipped with hand washing facilities. However we noted that some chairs were stained and one of the examining couches was ripped making it difficult to clean. The practice had identified the need to replace the chairs in a recent self-assessment of infection control.

The practice had infection and hazard control policies in place. Staff were trained in infection control and we saw the staff training matrix and new staff induction checklist covered infection control procedures. We also saw records showing that staff immunisations were up-to-date.

Antibacterial hand gel was available throughout the practice including at the reception desk. The practice was equipped with personal protective equipment including gloves, masks and disposable aprons. The practice used single-use and disposable supplies to reduce the risk of cross-infection. We checked some of these items at random and found that several sterile dressings were out of date.

The practice had a comprehensive cleaning plan and checklist. Cleaning products and equipment were stored separately and securely. There was a waste management contract in place for the collection of clinical waste, including sharps bins. We saw that sharps bins were properly installed and not overfull. There had been no "needlestick" injuries in the practice in recent years.

The practice manager and practice nurse had recently conducted a self-assessment on infection control in the practice. We were told that they were meeting with the NHS infection control leads at a nearby acute unit to discuss their findings and any potential improvements.

Staffing and recruitment

We reviewed the staff recruitment process. Recruitment checks were carried out by the Hurley Clinic Partnership human resources department which was located at a different site. We were provided with written confirmation that new members of staff underwent the required pre-employment checks including evidence of professional registration, Disclosure and Barring Service and satisfactory references. The practice had developed a locum pack which included a range of information about practice policy and procedures, local services and contacts.

The practice adjusted staffing levels in response to patient demand by changing the shift patterns of available clinical staff or securing additional locum support. For example, the number of staff increased at the beginning of the academic year to meet the additional demand for new patient registrations from students.

Are services safe?

The practice had experienced a period of considerable transition over the previous year with doctors, including partners, joining and leaving the practice during this time. Patient Participation Group members, patients and staff members commented on the difficulties this had created in terms of continuity of care. Since April 2014, around half of the clinical sessions were being covered by locum staff and there had been no lead GP in post. We were told by several members of staff that locum doctors had not turned up on two separate occasions meaning that appointments had to be cancelled.

The practice used locum doctors from a pool of doctors who worked across the Hurley Clinic Partnership practices. There were systems in place for local staff to feedback any concerns about locum staff that did not perform well. The salaried doctors told us they were confident in the skills of the locum doctors. However, the practice's recent high reliance on locums increased the risk of poor or fragmented care to patients. We were told that staff had raised safety concerns with the practice partners about this. The practice had subsequently mitigated the risks by securing the services of fewer locum doctors who were being used more regularly. We were also told that a lead GP had recently been recruited and would start later in the Summer.

Dealing with Emergencies

The practice had emergency equipment available including a defibrillator and oxygen. Staff completed regular checks of oxygen levels and defibrillator operation and we saw the records for this. Staff had received up-to-date training in basic life support and dealing with medical emergencies.

The practice had a business continuity plan which set out the arrangements to be followed in the event of major disruption. There were regular fire alarm tests and a designated evacuation assembly point. Exits and information about what to do in the event of fire were clearly displayed throughout the premises. Staff were trained in fire safety.

Equipment

The practice had policies and procedures covering the maintenance of equipment. We checked a number of pieces of medical equipment and saw these had been maintained and calibrated in line with the manufacturers' recommendations. Staff told us that they had enough equipment and did not experience any problems with maintenance, replacement or repair.

The practice nurse was responsible for ensuring adequate stocks of medical supplies were maintained, such as syringes, needles and dressings. The practice kept records of stock and equipment orders.

Are services effective?

(for example, treatment is effective)

Our findings

Promoting best practice

National Institute of Health and Care Excellence (NICE) guidelines were followed in the assessment and planning of patients' healthcare needs. Clinical staff received electronic alerts about new or updated clinical guidelines on the management of various conditions. The practice followed 'integrated pathways' of care for long term conditions such as asthma.

The practice followed national and locally agreed policies for referrals, for example, referring patients with cancers to be seen within two weeks and patients with a positive HIV test within 48 hours. The practice had an electronic referral template in place. This enabled the doctors to systematically obtain and assess the information needed to make a referral to the appropriate specialist.

Management, monitoring and improving outcomes for people

The practice was meeting most national and local targets for the management of a range of chronic conditions and had improved its performance on the Quality and Outcomes Framework (QOF) in 2013 and had a target to achieve 95% on the QoF in 2014. The QOF forms part of the national GP contract and rewards GP practice achievement across a range of targets. The targets cover the management of common long-term conditions; patient experience; the provision of additional services; and how well the practice is organised. The practice had identified areas of underperformance on its previous QOF performance. These included relatively low rates of child immunisation and cervical screening and had taken action to improve uptake, for example writing to families with children who were overdue their immunisation with a pre-booked appointment time.

The practice undertook clinical audits required to meet various QOF targets, enhanced service targets and participated in audit and benchmarking exercises organised collaboratively by the clinical commissioning group. Individual GPs had undertaken audits as part of their revalidation process, for example, on their prescribing of certain medicines and whether this was in line with guidance.

However, it was unclear to what extent the practice used clinical audit as the lead GP had left the practice and we were told this was part of their role. We were unable to review any examples of audit reports initiated or completed within the practice because staff were unable to access this information. At the time of the inspection, clinical audit was not being systematically used to drive improvement within the practice.

The practice manager completed a monthly performance return which was submitted to the GP partners electronically for review. Measures including QOF achievement, patient experience and efficiency measures were standardised and compared across all the practices managed by the Hurley Clinic Partnership. The Hurley Clinic Partnership's clinical governance committee reviewed the returns and contacted the practice if they had any concerns.

Staffing

The clinical staff ensured their practice was up-to-date and maintained records of their continuing professional development. The salaried GPs had undergone revalidation the previous year and all staff received an annual appraisal. Staff told us that they took advantage of development opportunities offered by the Hurley Clinic Partnership, the local clinical commissioning group and other NHS bodies, which included for example, monthly practice nurse meetings.

We saw email correspondence which showed that the practice manager identified and shared potential training and development opportunities with staff. The practice manager had been in post for around three months and had started to review and monitor staff attendance at mandatory training.

Mentoring and supervision opportunities were potentially available across the Hurley group but in practice, day-to-day opportunities for clinical supervision and support for the doctors had been limited in recent months by the departure of the lead GP.

Working with other services

The practice worked in partnership with a range of external professionals in both primary and secondary care to ensure a joined up approach for patients. The practice ran multidisciplinary team meetings each month to consider the case management of patients with complex needs and any patients coming to the end of their life. These meetings were attended by one of the salaried GPs, the practice nurse and community health services staff.

Are services effective?

(for example, treatment is effective)

The practice also facilitated patients' access to the Improving Access to Psychological Therapies programme which provided support for patients with common mental health difficulties such as stress, worry and low esteem.

Around 60% of patients at the practice were students at Goldsmiths University. The practice had entered into a private contract with the University to better meet students' needs, particularly around mental health. For example, students experiencing mental distress were offered rapid access to counselling.

The practice also had a number of older patients who lived in a nearby supported living scheme, several of whom were frail with multiple health problems which needed regular review. One of the GPs made routine visits to the scheme on a weekly basis. The scheme manager told us that the continuity of care and communication from the practice was excellent. They said this helped people to continue living as independently as possible.

Health, promotion and prevention

The practice participated in national screening and health promotion programmes and offered screening for chlamydia infection. All new patients were offered a health check which included advice on health promotion tailored to the individual's needs. There was a poster in the waiting area informing patients between the ages of 40 and 74 about free health checks to assess and reduce the risk of developing heart disease and other common long-term conditions.

The practice had installed an electronic health monitoring station in the main waiting area with instructions. This enabled patients to check their own height, weight, pulse rate and blood pressure. We saw patients making use of the equipment. There was a system in place for the results to be recorded in the patient's notes. Patients with concerning results were referred to a doctor for follow-up.

The health care assistant provided health promotion advice. They were able to refer patients to more specialist services for example, exercise and smoking cessation services when appropriate. The health care assistant had been trained for their role and was booked on further training to develop their knowledge of sexual health.

There was a range of health promotion information in the waiting areas. Information covered HIV testing, chlamydia testing, lung cancer, breast screening, shingles vaccine, back ache, meningitis, overuse of antibiotics, child immunisation and smoking cessation. However there was little information specifically targeted at students. We were told that tailored information for individuals could be printed from the electronic computer system and two patients we spoke with confirmed they had been given useful written information by their doctor.

The practice had recently introduced an internet telehealth service. This was accessible online from the practice website and included information about health, lifestyle and self-care for over 100 conditions. Patients were also able to access advice from a pharmacist, nurse or their own GP.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

All the patients we spoke with described the service as caring and compassionate. A patient said the doctor recognised when she was in pain and had a caring approach when assisting her to move during the consultation. The practice's own survey found that most patients thought they were treated with dignity and respect. In the 2014 national GP patient survey, 74% of patients said the last GP they saw or spoke to was good at treating them with care and concern and 76% said the last nurse they saw or spoke to was good at listening to them. Eighty-three per cent of respondents would recommend the practice.

Patients were supported emotionally. Patients praised individual doctors and the nurse for their sensitive approach. One patient described how the doctor provided her with reassurance and support when she was very unwell. The practice referred patients to Lewisham Bereavement Counselling Services, and the practice had obtained leaflets about the service although these had not yet been put out in the waiting rooms.

The chaperone policy was displayed in the waiting room and stated that patients could bring a family member into examinations or that they could request a member of staff act as a formal chaperone. Clinical staff were usually called to act as chaperones but if they were unavailable, reception staff would assist. We asked one of the receptionists about this and they were able to effectively describe the chaperone role and had received training from the practice nurse. Patients we spoke with had not been verbally offered a chaperone.

Involvement in decisions and consent

During the inspection we saw that patients were usually greeted politely by the reception staff. We saw some good interactions between staff and patients. For example, we saw the receptionists taking care to explain practice procedures in a way people could understand.

Measures were in place to protect patients' privacy. Receptionists took care not to repeat patients' date of birth or discuss confidential information over the phone in a way that would allow others to identify the person. The receptionists told us that sometimes patients wanted to discuss something more privately and they could take them to a quiet area. There was no written notice informing patients that this was possible however. Treatment rooms were equipped with curtains to help protect patients' privacy during physical examination. Consultations could not be overheard from the waiting area. Staff ensured that confidential information was not openly visible to others.

The clinical staff told us they sought verbal consent from patients before any examination, treatment, referral or immunisation and understood their role under the Mental Capacity Act 2005. The practice used a telephone interpreting service to ensure that patients whose first language was not English were able to give informed consent to care. One patient we spoke with recalled being asked for their consent before an examination. Clinical staff told us they tried to involve children in their care and would obtain a child's consent if they were able to understand what was being proposed. The doctors were aware of the 'Gillick guidelines' to assess younger patients' maturity to make decisions without the consent of their parents when this was appropriate.

The practice had a Patient Participation Group which had helped design the practice feedback survey. The practice had responded to suggestions made by the group, for example to obtain more information about local bereavement services for patients.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided a service to a diverse population with a wide range of needs. Most of the patients we spoke with and who completed comments cards said the practice met their needs. This was echoed in the practice's own surveys. One patient we met who was pregnant had chosen to have a home birth and said the practice and local community midwifery team were positively supporting this.

The practice was able to demonstrate an understanding and awareness of the needs of the local population including students, people with enduring mental health needs, frail older people and people in vulnerable circumstances. The practice had identified sexual health and mental health services as being particularly important for the student population. Students and other patients could access counselling at the practice.

The practice engaged with commissioners and other providers to co-ordinate and provide integrated care to meet the needs of the different patient groups it served. The practice participated in a number of "local enhanced services" (LES) schemes to improve the management and delivery of care to specific patient groups, for example patients with Alzheimer's disease.

There were appropriate arrangements in place for obtaining, communicating and following up the results of diagnostic tests. One of the GPs we spoke gave us examples of how they had followed-up vulnerable patients following referral and discharge from specialist care, for example, detoxification services.

The practice had written to patients over 75 to inform them of the named GP initiative and their named GP. Currently this responsibility rested with just one GP due to staff departures which was not sustainable in the longer term. The practice had around 60 registered patients who were over 75. The practice also provided a named GP to a small group of patients with enduring mental health needs who lived in a nearby supported living scheme. These patients were able to access the doctor who was familiar with their history and treatment at each appointment.

The practice nurse told us the newly appointed lead-GP had a special interest in diabetes. She was planning to develop her skills to offer 'insulin starts' with the lead-GP's support (ie initiating insulin therapy with certain patients with type 2 diabetes). This would reduce the need for referral and maintain good continuity of care for this group of patients.

Access to the service

The practice was accessible. Patients were positive about the appointments system. They said they were able to get through to the practice on the telephone without undue difficulty. They could arrange urgent appointments when they needed them and did not have a long wait for non-urgent appointments which were usually available within a week. The GPs carried out home visits to patients not well enough to attend the surgery. The practice was open every weekday and open until 8.00pm on Tuesdays. The practice had recently changed its telephone appointment system so people could book appointments as soon as the practice opened at 8.00am. Previously they had been asked to ring back half an hour later when the surgery started.

Information leaflets and posters informing patients about out of hours services were available in the waiting areas. Patients were directed to a nearby GP walk-in centre, an out of hours primary care service and an urgent care centre. Most of the patients we met were aware of the GP walk-in centre but not the other services.

Some patients reported difficulty in seeing their preferred doctor or the same doctor each time they visited. The 2014 national GP patient survey found that 44% of respondents reported not being able to see their preferred GP which was below the regional average. One patient said they had seen a different doctor every time they visited. For some patients this greatly affected their experience of care and their confidence in the practice. We spoke with a representative of the Patient Participation Group (PPG) who said that the departure of long-standing doctors had been very abrupt and destabilising to patients although the PPG understood that it was not always possible to share information with the public in advance. Staff told us they had seen an increase in verbal complaints and negative feedback about the lack of continuity of care from patients during this period and this had in turn affected morale in the practice.

We observed that although the waiting room was busy at certain times, all patients were able to sit and wait for their appointment. Patients reported that waiting times had

Are services responsive to people's needs?

(for example, to feedback?)

improved and varied from five minutes to 30 minutes, however patients said reception staff did not inform patients regarding delays. One patient said that the doctors were very apologetic if they were running late.

The practice offered electronic prescribing, online appointment booking and had recently introduced a telehealth service which allowed patients registered with the practice to consult with a pharmacist, nurse or with their own GP through structured online interaction. It was too early to evaluate the uptake of this service although staff anticipated it might be attractive to students and patients of working age. Patients were able to use the national electronic 'choose and book' service to choose a suitable time and location for their first hospital appointment.

At the time of the inspection, the salaried doctors at the practice were both female. We were told that this was taken into account when booking locums so that there were usually both male and female doctors in attendance should patients express a preference.

Practice staff used a telephone interpreting service to help communication with patients whose first language was not English. Patients could tick a form on their initial registration form if they required an interpreter during consultations. This would be logged on the practice computer system so that an alert would appear every time the patient booked an appointment. A double appointment of 20 minutes would be booked for patients who required an interpreter.

Concerns and complaints

The practice had a complaints process in place. Complaints were documented, investigated and reviewed by the practice partners for learning. We reviewed the complaints the practice had recently received. These had been managed in line with practice policy. We saw that letters to complainants were written clearly and included an explanation when a complaint had been upheld.

The practice had a written leaflet detailing the complaints procedure. This included clear information for patients about how to make a complaint, how any complaint would be handled and further options if they were not satisfied with the practice's response. A patient we spoke with had previously made a complaint when the reception staff had not logged their arrival to see the doctor. The patient waited an hour before staff had realised. The patient complained in writing, received a timely response from the practice manager, and the patient was satisfied with the outcome which was an apology from the practice manager.

It was also practice policy to respond to all comments made on the NHS Choices website. When patients raised concerns on the NHS website about the service, they were invited to contact the practice directly so the staff could investigate and learn from the feedback.

Are services well-led?

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

Our findings

Leadership and culture

The practice had experienced some turnover of staff. Two new GP partners had joined the service the previous year. The lead GP had left the practice in April 2014 and the previous practice manager had also recently left. The practice had recruited a new practice manager and a lead GP who was yet to start. All the staff we spoke with were very positive about the new practice manager and the difference they were making to the organisation of the practice.

The practice had been without a lead GP for over three months at the time of the inspection. Throughout this period the salaried doctors were able to call on the GP partners, who were located elsewhere, for advice and support. The partners were described as responsive in this role but their support was reactive. There was little evidence of active clinical leadership while the lead GP post was vacant.

The GP partners communicated with staff by email for example with formal feedback from incidents and complaints but were not 'visible' leaders at a time of uncertainty for staff and patients. We were told one of the GP partners had visited the practice on one occasion to meet staff. They had discussed their plans for the practice as part of the Hurley Clinic Partnership which staff said they found helpful and reassuring. The patient participation group members we spoke with were unaware of who the new GP partners were and had never met them.

Governance arrangements

The practice had governance structures in place. The management structure and individual roles and responsibilities were clear to staff. The practice was being run as part of the Hurley Clinic Partnership. Two of the practice's GP partners were also partners of the Hurley Clinic Partnership.

The Hurley Clinic Partnership had developed a set of performance indicators that practices were encouraged to meet, for example, practices were expected to achieve 95% on the Quality and Outcomes Framework. High performing practices and staff were recognised, for example, with awards for the best practice-based community engagement initiatives.

Some aspects of governance and oversight needed improvement. We found that monitoring procedures, such as fridge temperature checks were not always fully carried out. The practice had not formally notified the Care Quality Commission of changes to the partnership as required. The regional managers said they had been verbally assured that the notifications had been made but had not otherwise checked.

Systems to monitor and improve quality and improvement

The practice manager tracked practice performance on a range of standardised measures which included patient feedback, patient outcome measures provided by the clinical commissioning group and QOF achievement. The salaried doctors based at the practice were less clear about this and told us this was the remit of the lead GP post. The recently appointed lead GP had not yet started at the practice.

We were told that a representative from the practice usually attended clinical commissioning group meetings to share information and this was a useful exercise. The practice also participated in local benchmarking meetings.

The Hurley Clinic Partnership had a clinical governance committee covering all practices within the group including New Cross Health Centre. The committee met monthly and reviewed performance returns, complaints and incidents.

Patient experience and involvement

The practice had a Patient Participation Group. The group comprised of around six members and met every two months. The group had helped to design the practice patient survey and had identified a number of issues which affected patients. The practice manager attended the patient participation group meetings and responded to the group's feedback. The Patient Participation Group was not representative of the wider practice population as, for example, there were no student members at the time of the inspection.

Staff engagement and involvement

Staff met regularly to discuss and reflect on the service. We noted that the practice had recently experienced a rapid change of doctors with two partners no longer regularly working at the practice and two salaried doctors leaving or about to leave. We were told that this was partly because the Hurley Clinic Partnership provided career opportunities for clinical staff to develop their careers in different

Are services well-led?

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

environments and roles across the group. Exit interviews were conducted with staff leaving the Hurley group. Recent interviews had revealed that staff were leaving to achieve particular personal development opportunities, for example working overseas. Staff told us that the practice was a positive working environment.

The practice manager organised regular staff meetings and we saw the minutes of recent meetings which covered updates, training issues and learning. All the staff we spoke with said that the meetings were a positive opportunity to raise concerns or make suggestions. The salaried doctors met weekly with the practice manager but these meetings were relatively informal and were not minuted. The doctors told us they used this time to reflect on challenging cases and any other issues such as the progress of complaints or safeguarding cases.

Learning and improvement

There was an open reporting culture within the practice. Staff were comfortable discussing incidents that had occurred and actions they had taken to prevent the risk of recurrence. Staff were keen to use incidents as learning opportunities. We were told that staff members were positively encouraged to report incidents without delay.

The practice had achieved improvement in immunisation and cervical screening uptake rates over the previous year. The practice had made these areas a priority for improvement and used the IT system to generate alerts when eligible patients contacted the practice and individually followed-up standard invitation letters to improve patient participation.

We were not able to access audit records during the inspection and so did not see whether or how the practice systematically used audit to improve care. Current staff members were not sure where these records were located or what audits had been undertaken within the practice over the previous year.

Identification and management of risk

The practice did not keep a risk register. Over half of clinical sessions were being covered by locums and patients' experience of continuity of care had suffered following the departure of the lead GP. The practice had mitigated the risks to some extent following concerns raised by staff. The practice was increasingly using a smaller number of regular locums and providing one of the salaried GPs with more administrative time to follow-up on complex cases. The GP partners did not appear to be proactively managing risk effectively in the absence of a lead GP at the practice.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had a relatively small population of older people and older carers. Approximately 60 patients were aged over 75. We were told that these patients had a named GP and would be offered a health check and review in line with current guidance. Although this group of patients was small, we were told that the practice had recruited a new lead-GP with a clinical interest and background in the primary care of older people. The staff told us this was a positive development and would help ensure that the practice provided high quality care to this patient group.

The GPs visited patients at home if they were housebound or too unwell to attend the practice premises. The practice's frailest older patients lived in a nearby residential supported living scheme. One of the GPs visited the scheme weekly in order to review people's care and progress and for the early detection of any new health problems. We spoke with the manager of the supported living scheme who said that people using the service received good care from the practice and the doctors were caring. They said the service helped people to continue to live as independently as possible.

The practice manager had obtained patient information leaflets about bereavement services after this had been suggested by the patient participation group. At the time of the inspection, the practice did not have any patients receiving end-of-life care

The practice participated in a number of "local enhanced services" schemes to improve the management and delivery of care to specific patient groups, such as older patients. For example, patients at risk of dementia were identified through screening. The practice also ran a weekly multidisciplinary team meeting to review the cases of patients with complex needs. The meeting was attended by community nurses, a nurse from the supported living scheme and the GPs. The meeting helped to ensure that patients received coordinated and timely care from the right health professionals with the aim of reducing unnecessary hospital admissions.

Older people were offered appropriate vaccinations, for example eligible older patients were offered vaccination against shingles. The practice was accessible to patients with mobility difficulties.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice had systems in place to care for people with long term conditions. The practice was meeting most Quality and Outcomes Framework (QOF) national targets for the management of various long term conditions. Clinical staff received alerts about new or updated clinical guidelines on the management of various conditions.

The practice kept registers of patients with certain long term conditions and recalled patients for regular review. For example, patients with asthma had their prescribed steroids reviewed to ensure they were still suitable.

The practice participated in a number of "local enhanced services" schemes to improve the management and delivery of care to specific patient groups with long term conditions, for example schemes for chronic obstructive pulmonary disease (COPD) and patients with complex long-term conditions.

The GPs gave us examples of how they had followed-up patients following discharge from hospital to ensure patients had the right medicines and on-going support. GPs were aware of and referred patients to a wide range of specialist acute and community services for particular conditions.

The practice had recruited a new lead-GP with a clinical interest and background in the management of diabetes. As a result the practice nurse told us they planned to offer 'insulin starts' in the practice (that is, initiate insulin therapy to certain patients with type 2 diabetes) to avoid the need for onward referral. This had been identified through the Quality and Outcomes Framework (QOF) as an area of improvement for the practice.

The practice monitored its performance against the QOF and submitted monthly returns to the practice partners for comparative review. The QOF was a strong driver for improvement in relation to the management of long term conditions in the practice. However, the practice staff were unable to show us evidence of clinical audit cycles or how they had used audit evidence to assess and improve the management of long term conditions.

The service had recently undergone a period of transition and was using locum staff to cover a high number of clinical sessions. This increased the risk of poor or fragmented care particularly for patients with long term conditions.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice was improving its performance in meeting national targets in relation to primary care services for children. The practice monitored its child-immunisation rates and had identified this as an area for improvement. It had followed-up invitations by routinely booking appointments for children rather than waiting for parents to do this. Childhood immunisation rates had increased from 56% to 77%.

The practice provided ante-natal care in partnership with the local community midwifery team. One patient we spoke with who was pregnant had chosen to have a home birth and this was being positively supported by the practice. The practice did not offer a baby clinic but directed women to the nearby clinic at the Waldron Health Centre.

The doctors were aware of the "Gillick" guidelines and used these to assess younger patients' maturity to make decisions without the consent of their parents when this was appropriate.

Staff were aware of child protection and safeguarding procedures and reported concerns to the practice manager in the first instance. Staff had taken action when they had concerns about potential abuse and child neglect and were confident about their role in reporting concerns and the importance of doing so without delay. There were effective arrangements in place for reporting allegations of abuse in line with national and statutory guidance. Practice policy was for all staff to receive regular training in child protection but some clinical staff training was out-of-date.

Practice staff liaised with other professionals, such as health visitors, involved in the health and social care of children and young people. The electronic records system alerted staff when a child or young person known to social services attended the practice.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The majority of the practice population was of working age. The practice operated with extended opening hours on Tuesday evenings.

The practice offered electronic prescribing, online appointment booking and had recently introduced a telehealth service which allowed patients registered with the practice to consult with a pharmacist, nurse or with their own GP through structured online interaction. It was too early to evaluate the uptake of this service although staff anticipated it might be attractive to students and patients of working age.

We were told that approximately 60% of patients were students at Goldsmiths University. Practice staff engaged with the local student population by attending the university's 'freshers fair' and encouraging students to register with a doctor. The number of staff was increased at the start of the academic year to cope with the increase in new registrations.

The practice provided services to a young, mobile and sexually active population. All newly registering patients were offered HIV screening and vaccination for Hepatitis B as a matter of course, with rapid access to specialist services if required. The practice actively promoted self-testing kits for chlamydia.

The practice had entered into a private contract with the university to better meet students' needs, particularly around mental health. For example, students experiencing mental distress were offered rapid access to counselling.

The patient participation group was not representative of the wider practice population and did not currently include any student members.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice had a policy of never turning new patients away regardless of their circumstances or status. We were told the practice tried to remove barriers to access. For example, the practice did not require patients in difficult circumstances to produce proof of identity or address. The practice had a procedure in place so that new patients presenting with complex needs or in vulnerable circumstances would be directed to the duty doctor.

Staff consistently told us they were committed to providing good care to patients whatever their circumstances. The receptionists said the computer system alerted them when patients had been identified as having particular needs, for example for continuity of care or longer appointments. Staff were able to identify examples of how they supported patients with more challenging needs, for example by ensuring only certain receptionists greeted one patient suffering from anxiety.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice had identified mental health as a high priority given the prevalence of mental health needs in the local area and the needs of students. As a result, the practice offered counselling and cognitive behavioural therapy on the premises and rapid access to support services for students in mental distress.

The practice facilitated patients' access to the Improving Access to Psychological Therapies (IAPT) programme which provided support for patients with common mental health difficulties such as stress, worry and low self-esteem. An IAPT counsellor was located on-site three days a week. The IAPT Lewisham leaflet was displayed in the waiting room and included a self-referral form.

There were arrangements for monitoring patients' medicines and we were given examples of medicines reviews for patients on anticonvulsant and mood stabilising medicines. Patient records were flagged to identify when they were due for a medicines review and arrangements were made for them to attend the surgery or receive a home visit for this.

The practice offered an annual review to patients experiencing poor mental health as part of the Quality and Outcomes Framework.

Patients were referred to specialist mental health care services when this was required. The practice provided primary care services to a group of patients with enduring mental health needs living in a supported housing scheme. These patients were able to access the doctor who was familiar with their history and treatment at each appointment.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider did not ensure that appropriate steps were taken to protect patients from the risk of abuse. Staff refresher training on safeguarding was overdue.** **Regulation 11(a)(b)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have fully effective systems to assess and monitor the quality of the service and identify and manage risks. In particular, there was a lack of clinical leadership at the practice, clinical audit was not being used to drive improvement and monitoring checks, for example of the fridge temperature, were incomplete.** **Regulation 10 (1)(a)(b) 2(c)(i)(ii)**

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider was not ensuring that patients were protected against identifiable risks of acquiring a health care associated infection. This was because the practice was not maintaining appropriate standards of cleanliness and hygiene in relation to the premises and materials used in the treatment of patients.** **Regulation 12 (1)(a)(2)(c)(i)(iii)**