Home Health Service Limited

10 Harley Street

Inspection report

10 Harley Street
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Overall summary

We carried out an announced comprehensive inspection on 22 May 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and Regulations associated with the Health and Social Care Act 2008.

10 Harley Street is an independent health service based in London and Hertfordshire.

Our key findings were:

- The service had appropriate systems to safeguard children and vulnerable adults from abuse, although at the time of inspection the GP had not completed up to date adult safeguarding training.
- The GP had had an enhanced Disclosure and Barring Service (DBS) check and was registered with the General Medical Council (GMC).
- At the time of inspection no emergency medicines were carried by the GP to home visits and no risk assessment had been completed to support this decision. No risk assessment had been completed in respect of the emergency equipment available at the 10 Harley Street premises.
- There was no process detailing how patients were informed that there were no chaperones available for home visits. No risk assessment had been completed regarding staff who could act as chaperones at 10 Harley Street having appropriate chaperone training and DBS checks.

Summary of findings

- Clinical equipment used by the GP such as the portable blood pressure machine and adult pulse oximeter had not been calibrated.
- The GP received medicines and other safety alerts by email from the Independent Doctors Federation, and demonstrated an awareness of recent safety alerts, although there was no system in place to document these.
- Individual care records were written and managed in a way that kept patients safe, and referral letters were thorough and contained all of the necessary information.
- Blank prescriptions were kept securely and arrangements for dispensing medicines at the service kept patients safe.
- Vaccines were occasionally stored overnight in a domestic fridge.
- There were policies in place for critical incidents and complaints, and the service was aware of the requirements of the Duty of Candour.
- Patient records we reviewed demonstrated appropriate assessment, care and treatment.
- The GP provided a detailed written report to each patient after their consultation for them to forward on to their NHS GP.
- The GP administered vaccines and child immunisations and had not completed any training or updates in this area to ensure they were maintaining competency and keeping up to date with best practice.
- The service had not reviewed the effectiveness and appropriateness of the clinical care provided to patients through any quality improvement activity, such as clinical audits.
- The GP had not completed any recent Mental Capacity Act training, but they understood the requirements of legislation and guidance when considering consent and decision making. However, verbal consent from patients was not recorded.
- The service gave patients timely support and information, patient 'thank you' cards were positive, and the service recognised the importance of patients' privacy and dignity.
- The service organised and delivered services to meet patients' needs and the appointment system was easy to use.
- The GP was responsible for the organisational direction and development of the service and the day to day running of it.
- The service did not have an adequate process to verify patients' identities, including checking that adults attending with children had parental responsibility and documenting this.

We saw one area of notable practice:

- The GP telephoned all patients two or three days after their appointment to check how they were feeling and if they required any further assistance.

We identified regulations that were not being met and the provider **must**:

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

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider could make improvements and **should**:

- Consider the process for patient identification, including checking and documenting parental responsibility for adults bringing children to appointments.
- Review the necessity for a written protocol for prescribing high risk medicines.
- Review training requirements in relation to the Mental Capacity Act and administering vaccines and immunisations.
- Consider the necessity for interpretation services for patients whose first language is not English.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- The service had appropriate systems to safeguard children and vulnerable adults from abuse, although at the time of inspection the GP had not completed up to date adult safeguarding training.
- At the time of inspection no emergency medicines were carried by the GP to home visits and no risk assessment had been completed to support this decision.
- Chaperones were not available for home visits and there was no system to inform patients of this in advance of their appointment.
- The GP's clinical equipment such as the portable blood pressure machine and adult pulse oximeter had not been calibrated.
- Vaccines were occasionally stored overnight in a domestic fridge.
- The GP received medicines and other safety alerts by email from the Independent Doctors Federation, and demonstrated an awareness of recent safety alerts, although there was no system in place to document these.
- Individual care records were written and managed in a way that kept patients safe, and referral letters were thorough and contained all of the necessary information.
- Blank prescriptions were kept securely and arrangements for dispensing medicines at the service kept patients safe.
- There were policies in place for critical incidents and complaints, and the service was aware of the requirements of the Duty of Candour.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- Patient records we reviewed demonstrated appropriate assessment, care and treatment.
- The GP administered vaccines and child immunisations and had not completed any training or updates in this area to ensure they were maintaining competency and keeping up to date with best practice.
- The service had not reviewed the effectiveness and appropriateness of the clinical care provided through any quality improvement activity, such as clinical audits.
- The GP provided a detailed written report to each patient after their consultation for them to forward on to their NHS GP.
- The GP had not completed any recent Mental Capacity Act training, however they understood the requirements of legislation and guidance when considering consent and decision making.
- Verbal consent from patients was not recorded.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- The service gave patients timely support and information.
- The GP telephoned all patients two or three days after their appointment to check how they were feeling and if they required any further assistance.

Summary of findings

- We saw some examples of positive cards sent by patients to the GP following their appointments thanking them for the care and treatment provided. One returned patient questionnaire evaluated their appointment as 'excellent' overall and the GP was evaluated as 'excellent' for their explanation of diagnosis and treatment.
- The service recognised the importance of patients' privacy and dignity; it complied with the Data Protection Act 1998 and was registered with the Information Commissioner's Office.
- We saw there was a privacy screen available for patients in the consultation room at 10 Harley Street if needed to maintain dignity.
- The service did not offer interpretation services.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

- The service organised and delivered services to meet patients' needs.
- The appointments system was easy to use.
- Home visits were available, as well as consultations at the 10 Harley Street premises.
- We saw the service's complaints policy which detailed how patients could make a complaint. The service had not received any complaints in the last year.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- The service did not have an adequate process to verify patients' identities, including checking that adults attending with children had parental responsibility and documenting this.
- There were no systems for ensuring oversight and management of some risks, including in relation to emergency equipment and chaperones.
- The GP was responsible for the organisational direction and development of the service and the day to day running of it.
- The service had a clear vision – to offer patients an accessible and convenient GP service at times when their own NHS GP was not available.

10 Harley Street

Detailed findings

Background to this inspection

10 Harley Street is an independent health service based in London and Hertfordshire. The provider, Home Health Service Limited, offers private GP services to both adults and children. The service provides home visits to patients in parts of London and Hertfordshire, and consultations at 10 Harley Street in central London. The service rents the room at 10 Harley Street when necessary, but staff who work at these premises are not employed by the provider.

At the time of inspection, there had been no patient appointments at the 10 Harley Street premises since September 2016. The provider stated that, in the 12 months prior to the inspection, they had completed approximately two home visits per week to patients.

The service is registered with the CQC to provide the regulated activity of treatment of disease, disorder and injury.

Appointments are available upon request at the 10 Harley Street premises from Monday to Friday from 9am to 8pm and on weekends from 9am to 5pm. Home visits are available from Monday to Sunday from 8am to 10pm.

The sole GP at the service, who runs Home Health Service Limited, is the registered manager. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out this inspection as a part of our comprehensive inspection programme of independent health providers.

Our inspection team was led by a CQC lead inspector, who was supported by a GP specialist advisor.

The inspection was carried out on 22 May 2018 and we attended the 10 Harley Street premises where the GP sometimes carries out appointments. During the visit we:

- Spoke with the GP.
- Reviewed a sample of patient care and treatment records.
- Reviewed patient feedback.

We asked for CQC comment cards to be completed by patients prior to the inspection and these were sent to 10 Harley Street in central London. No patients attended an appointment at the 10 Harley Street premises during the two weeks the comment cards were available, and therefore no comment cards had been completed.

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?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

We found that this service was not providing safe care in accordance with the relevant regulations.

Safety systems and processes

- The service had appropriate systems to safeguard children and vulnerable adults from abuse, and the GP knew how to recognise and report potential safeguarding concerns. The service had a child protection algorithm in place which detailed the process for reporting concerns about children. We saw evidence that the GP had completed level 3 child safeguarding training in March 2018. However, at the time of inspection, the GP had not completed any adult safeguarding training since February 2014. Following the inspection, we received evidence that the GP had completed adult safeguarding training on 19 June 2018.
- The GP was registered with the General Medical Council (GMC) and was subject to professional revalidation.
- The GP had an enhanced 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).
- The service did not offer chaperones to patients when carrying out home visits, and this information was not made clear to patients on the service's website and there was no system to inform patients of this in advance of their appointment.
- The GP said that if a patient requested a chaperone for an appointment at the 10 Harley Street premises, he would ask the reception staff working there if a chaperone was available. However, as staff at the 10 Harley Street premises were not employed by the provider, the GP could not be assured that the person acting as a chaperone would have had chaperone training or a DBS check. There was no documented risk assessment completed by the GP to ensure that staff who could be used as a chaperone had appropriate training and checks. The GP told us that they had not seen any patients at 10 Harley Street since September 2016.
- The service maintained appropriate standards of cleanliness and hygiene. The landlords were responsible for cleaning the 10 Harley Street premises and we saw cleaning schedules in place. There was an effective system to manage infection prevention and control, and systems for safely managing healthcare waste, including when the GP undertook home visits.
- The landlord for the 10 Harley Street premises had health and safety policies in place. A legionella risk assessment had been carried out on 31 May 2017, which did not identify any hazards to be actioned. Fire safety equipment was regularly tested and fire drills were completed annually. We saw the most recent fire alarm test was on 22 May 2018, and the most recent fire drill was on 17 July 2017.
- The landlord for the 10 Harley Street premises was responsible for electrical equipment safety checks (PAT) and these were up to date. However, calibration of the equipment was the responsibility of the GP and some of the items used during consultations had not been calibrated since purchase to ensure they were in good working order, including a portable blood pressure machine and adult pulse oximeter.

Risks to patients

- The GP understood their responsibility to recognise those in need of urgent medical attention and knew how to identify and manage patients with severe infections, for example, sepsis.
- We saw evidence that the GP had received basic life support training in November 2017.
- On the day of inspection the GP told us that they did not carry any medicines to treat patients in an emergency, such as medicines to treat anaphylaxis. At the 10 Harley Street premises the defibrillator battery had expired and there was no medical oxygen available. The GP was not aware of who checks the defibrillator battery or why there was no oxygen on the premises, and had not completed a risk assessment in respect of the emergency equipment available at 10 Harley Street.
- Following the inspection, the GP sent us a copy of a risk assessment to support the decision for not carrying certain emergency medicines to home visits, and evidence that they had purchased adrenaline (to treat anaphylaxis or acute angio-oedema), rectal diazepam (to treat an epileptic fit), hydrocortisone injection (to treat acute severe asthma or severe anaphylaxis), and amoxicillin (to treat bacterial infections). The GP had assessed there was no need to carry benzylpenicillin to

Are services safe?

treat suspected bacterial meningitis, as they were unlikely to visit a patient with suspected meningitis and would call 999. The GP also reported they never used benzylpenicillin working as an NHS GP for 15 years.
- The GP carried an adult pulse oximeter, but not a paediatric pulse oximeter for children. Following the inspection, we received evidence that a paediatric pulse oximeter had been ordered.
- We saw evidence that there were appropriate professional indemnity arrangements in place for the GP.
- The service asked patients for their name, address, date of birth and contact details when they registered, and did not require any other identification to verify this information. When we asked the GP how they could be assured that adults attending with a child for an appointment had parental responsibility, the GP said they would assume parental responsibility. Following the inspection, the GP contacted us to advise they routinely review every child's 'red book' to help corroborate their identity (the Personal Child Health Record, also known as the 'red book', is a national standard health and development record given to parents or carers at a child's birth), and provided one patient record which documented that the child's 'red book' had been seen.
- The GP received medicines and other safety alerts by email from the Independent Doctors Federation, and demonstrated an awareness of some recent safety alerts. There were no systems in place to record and act upon these alerts, as the GP was the only clinician at the service and they would review the alerts as and when they were received. The GP said that the majority of alerts would not be relevant to the patients they saw and so we were unable to see evidence of any actions being taken as a result of alerts.
- The practice did not formally monitor or review its performance in order to understand risks and initiate safety improvements.

Information to deliver safe care and treatment

- Individual care records were written and managed in a way that kept patients safe. The GP would complete contemporaneous paper records during consultations with patients, and these would then be transferred to the service's computer system.
- We viewed a sample of patient records on the computer system which showed that information needed to deliver safe care and treatment was available an accessible way.
- We saw that referral letters to other healthcare professionals or services were thorough and included all of the necessary information.

Safe and appropriate use of medicines

- Blank prescriptions were kept securely.
- Arrangements for dispensing medicines at the service kept patients safe. The GP would affix handwritten labels to dispensed medicines which contained all the required information.
- The service had an appropriate controlled drugs prescribing protocol in place. The GP explained that he did not often prescribe controlled drugs, but would use the appropriate private prescription form for Schedule 2 and 3 controlled drugs.
- We saw evidence of good antimicrobial stewardship, such as in relation to the treatment of urinary tract infections.
- Patients' health was monitored to ensure medicines were being used safely, as the GP telephoned patients two or three days after their appointment to check how they were feeling and if they required any further assistance.
- During the inspection we asked whether the service prescribed any high risk medicines, such as methotrexate or warfarin. The GP confirmed that they have not prescribed these and there was no written protocol for prescribing high risk medicines.
- The GP said he checks the expiry dates of his medicines stock on a quarterly basis, but that this was not documented. However, we saw evidence of a yearly stock check which recorded the stock level and medicines expiry dates.
- The service administered vaccines to patients, which were usually collected by the GP from the pharmacy on the day of the appointment. The GP told us that, on occasions, they would collect vaccines from the pharmacy to administer to a patient the following day, in which case they would store the vaccine in a compartment in their domestic fridge at home overnight with no temperature checks and no cold chain transport. Public Health England guidance states that domestic fridges are not suitable for storing vaccines.

Are services safe?

Lessons learned and improvements made

- There were policies in place for critical incidents and complaints. We were told that any incidents or complaints would be discussed by the GP and the other business owner. However, there was no formal system such as an incident reporting form for capturing incidents or complaints.
- There had not been any incidents or complaints received in the last 12 months. The GP told us about an older incident, whereby the GP forgot to inform a child's family that not controlling the child's fever could lead to febrile convulsion; the GP telephoned the family two or three days after the appointment to check if the child was feeling better, and the family advised the child had been admitted to hospital as they had had a convulsion. The GP said that they apologised to the family for not giving advice about controlling the child's fever.
- The critical incidents policy set out that incidents would be recorded and analysed, the impact on those involved would be assessed, and any learning or improvements would be identified. The service was aware of the requirements of the Duty of Candour.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was not providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

- The service referred to the British National Formulary when delivering care to patients. The GP took account of guidelines for good antimicrobial stewardship.
- Patient records we reviewed demonstrated appropriate assessment, care and treatment.
- We saw no evidence of discrimination when making care and treatment decisions.
- The GP advised patients what to do if their condition got worse and where to seek further help and support.

Monitoring care and treatment

- The service had not reviewed the effectiveness and appropriateness of the clinical care provided through any quality improvement activity, such as clinical audits.
- We saw that the GP had reflected on three case studies as part of their GMC appraisal, and had completed internet searches to find out more about the particular health conditions involved. However, there was no evidence that these reflections had informed any changes or improvements to the service for patients.

Effective staffing

- The GP was the only clinician who worked for the service and was available to attend home visits to patients and consultations at the 10 Harley Street premises.
- The GP was registered with the GMC and we saw evidence of their completed appraisal from February 2018.
- We saw that the GP had attended various seminars and training updates during the previous 12 months including in relation to cardio-respiratory assessment, basic life support, dermatology, gastroenterology, male health, and ear, nose and throat (ENT) emergencies.
- The GP administered vaccines and child immunisations, but had not completed any training or updates in this area to ensure they were maintaining competency and keeping up to date with best practice.

Coordinating patient care and information sharing

- The service worked with other professionals to deliver care and treatment.
- The GP told us that they used to send a report directly to the patient's NHS GP after every consultation, but a few patients felt uncomfortable about this. The GP now provides a detailed written report to each patient after their consultation for them to forward on to their GP.
- We saw evidence that the GP referred patients to other healthcare specialists when necessary. Referral letters to other healthcare professionals or services were thorough and included all of the necessary information.
- We reviewed a sample of patient records and found that the service shared relevant information with and acted upon results from other services in a timely way.

Consent to care and treatment

- The GP had not completed any recent Mental Capacity Act training, however they understood the requirements of legislation and guidance when considering consent and decision making.
- The GP explained that verbal consent would be sought from patients for certain procedures, such as administering vaccines. However, this consent was not recorded in the patient records.

Are services caring?

Our findings

We found that this service was providing caring services in accordance with the relevant regulations.

Kindness, respect, and involvement in decisions about care

- The GP told us about cases he had dealt with which demonstrated an understanding of patients' personal and social needs.
- The service gave patients timely support and information.
- The GP telephoned all patients two or three days after their appointment to check how they were feeling and if they required any further assistance.
- No CQC comments cards had been completed as there had not been any consultations at the 10 Harley Street premises during the two weeks the comment cards were available. We saw examples of positive cards sent by patients to the GP following their appointments thanking them for the care and treatment provided.
- In May 2018 the service had started to gather patient feedback by handing out questionnaires to patients following their consultations. No analysis of results was available as only one had been returned by the day of inspection. The returned questionnaire was positive about the service received, and evaluated the appointment as 'excellent' overall. The GP was evaluated as 'excellent' for their explanation of diagnosis and treatment.
- We saw evidence in patient records that the GP explained side effects of medicines to patients and involved them in decisions about their care.
- The service did not offer interpretation services. The GP said that if a patient did not speak English they would usually bring a friend or family member to act as a translator, or they would use 'Google translate' if necessary.

Privacy and Dignity

- The service recognised the importance of patients' privacy and dignity.
- The service complied with the Data Protection Act 1998 and was registered with the Information Commissioner's Office.
- The service had a data protection policy which detailed the provider's responsibilities in relation to managing and processing personal information.
- Patient information and records were held securely. The service used an encrypted cloud-based system to store information, which was backed up every 30 minutes.
- We saw there was a privacy screen available for patients in the consultation room at 10 Harley Street if needed to maintain dignity.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that this service was providing responsive care in accordance with the relevant regulations.

Meeting people's needs and timely access

- The service organised and delivered services to meet patients' needs. The 10 Harley Street premises were appropriate for the services delivered and the GP offered home visits to patients living in parts of Hertfordshire and London.
- 10 Harley Street had wide doorways and an accessible lift for patients with mobility difficulties.
- Patients were able to access care and treatment from the service within an acceptable timescale for their needs. Appointments were available upon request at 10 Harley Street from Monday to Friday from 9am to 8pm and on weekends from 9am to 5pm. Home visits were available from Monday to Sunday from 8am to 10pm.
- The service offered extended consultations of 45 minutes.
- The appointment system was easy to use; patients could book appointments by telephone or via the service's website.
- Consultation costs were displayed on the website.

Listening and learning from concerns and complaints

- We saw the service's complaints policy which detailed how patients could make a complaint, either by putting their concerns in writing or arranging an appointment with one of the business owners to discuss the issue.
- The service's complaints policy demonstrated that patients would receive an explanation of what had happened, an apology where appropriate, and an explanation of what the service would do to prevent the issue happening again.
- The service had not received any complaints in the last year and the GP said there were no instances where changes had been made to the service as a result of complaints being received.

Are services well-led?

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

Our findings

We found that this service was not providing well-led care in accordance with the relevant regulations.

Leadership, culture and vision

- The GP was responsible for the organisational direction and development of the service and the day to day running of it.
- The service was aware of the requirements of the Duty of Candour and the critical incidents and complaints policies detailed the process that would be followed including that patients would receive an apology where appropriate.
- The GP completed GMC appraisals, which included reflection on cases, assessment of training needs and the implementation of a personal development plan.
- The service had a clear vision, to offer patients an accessible and convenient GP service at times when their own NHS GP was not available. The GP told us that they intended to continue the business with the core group of patients currently registered, but were not seeking to grow the number of patients using the service.

Governance arrangements and managing risks and performance

- Service specific policies and processes were in place. These included in relation to child safeguarding, complaints, critical incidents, prescribing of controlled drugs, data protection and needle-stick injuries.
- The service had a business continuity plan. If the service ceased to operate, the GP told us that patient records would be sent to patients, retained for the appropriate retention period by the service and then removed from the service's record system.
- The service did not have an adequate process to verify patients' identities, including checking that adults attending with children had parental responsibility and documenting this.
- The service did not have documented protocols in relation to prescribing high risk medicines.
- There were no systems for ensuring oversight and management of some risks, including in relation to emergency medicines and equipment and chaperones.
- Although the GP had appraisals with the GMC, the service had not carried out any audits to monitor and assess the GP's ongoing clinical performance.

Engagement with patients and external partners

- The service started carrying out patient surveys in May 2018 to seek patients' views about the care they were receiving. As of the inspection date, only one survey had been returned so no overall analysis was available.
- The GP worked with other specialists, such as Psychiatrists, to discuss patients' needs and ensure that these were addressed.

Continuous improvement and innovation

- The GP was a member of the Independent Doctor's Federation and attended seminars through this forum.
- We saw in the GP's GMC appraisal that changes had been made to the service; for example, the service had introduced Skype consultations to enable one of their patients to have an appointment with a Psychiatrist who was licensed to prescribe the specific controlled drugs needed by the patient.
- However, the service did not carry out any clinical audits to review and monitor the clinical care provided to patients.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • Adult safeguarding training was not up to date. • Verbal consent from patients was not recorded. • No emergency medicines were carried by the GP to home visits and there was no risk assessment to support this decision. There was no risk assessment in respect of the emergency equipment available at 10 Harley Street. • Vaccines were occasionally stored overnight in a domestic fridge. • The portable blood pressure machine and adult pulse oximeter had not been calibrated. • There was no process documenting how patients were informed that chaperones are not available for home visits and there was no risk assessment regarding staff at 10 Harley Street having appropriate chaperone training and DBS checks. **These matters are in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- No clinical quality improvement activity had been completed to review and monitor the clinical care being provided to patients, such as clinical audits.
- There were no systems for ensuring oversight and management of some risks, including in relation to emergency medicines and equipment and chaperones.

These matters are in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.