The Mathews Practice Belgrave

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Mathews Practice Belgrave on 1 November 2016. The overall rating for the practice was inadequate and the practice was placed into special measures for a period of six months. The full comprehensive report for the November 2016 inspection can be found by selecting the 'all reports' link for the Mathews practice on our website at www.cqc.org.uk.

As a result of the inspection on 1 November 2016 warning notices were served. The practice was re-inspected on 6 June 2017 to follow up on the warning notices and found to have completed the requirements of the notice.

This inspection was undertaken following the period of special measures and was an announced comprehensive inspection.

We found that the practice had made some improvement when we carried out the comprehensive inspection on 24 July 2017. However overall the practice is still rated as inadequate.

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

- Some staff were beginning to understand their responsibilities to raise concerns and to report incidents and near misses.
- Some risks to patients were being assessed.
- Information about how to complain was available and some lessons were being learned however the practice did not keep details of the investigations that were undertaken as a result of complaints.
- Some patients said they were treated with compassion, dignity and respect.

The areas where the provider must make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure specified information is available regarding each person employed.
- Establish effective governance systems and management processes in accordance with the fundamental standards of care to improve patient access to quality services.

Summary of findings

- Establish effective governance systems and management processes to ensure that: patients are kept safe in relation to: emergency guidance, patient confidentiality and improved communication with staff through significant event reporting.

The areas where the provider should make improvements are:

- Ensure the care and treatment of patients is appropriate, meets their needs and reflects their preferences.

This service was placed in special measures in November 2016. Insufficient improvements have been made such that the overall rating for The Mathews practice remains inadequate and the service will remain in special measures. Therefore we are taking action in line with our enforcement procedures which will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- Although some risks to patients were being assessed, the systems to address these risks were not implemented well enough to ensure patients were kept safe. For example, one of the practice nurses was using Patient Group Directions which were not authorised by a practice representative.
- The practice did not have access to a defibrillator on the premises because it was off site being repaired. No alternative arrangements were in place and a risk assessment had not been completed to identify how risks to patients would be managed.
- Emergency equipment was being checked on a monthly rather than on a weekly basis as per the Resuscitation Council guidelines (2015).
- There was no stock control of things in doctors bag (e.g. urine test strips expired in November 2015)
- Staff were using out of date Resuscitation Council Guidelines.
- Infection Prevention and Control audits had been completed at both sites however some actions were outstanding with no date for completion.
- The arrangements for the monitoring of medications requiring refrigeration was unsafe. For example, in one refrigerator the alarm temperature was set incorrectly (2-9 rather than 2-8).In another refrigerator only one thermometer, a data logger, was in place and the average temperature was being recorded rather than the minimum and maximum temperatures.
- On the day of inspection we observed staff using hand written notes rather than the chest pain protocol when ruling out emergency symptoms over the telephone. The chest pain protocol had been updated since the hand written notes were made.
- When checking staff recruitment files we noted that there was not satisfactory evidence for conduct of staff in previous employment. For example there was no application form or CV in place for a member of the practice nursing team.
- Although a new significant event process had been implemented, this system needed more proactive planning to ensure that events did not re-occur and a review date needed adding in order to monitor and track progress.

- Although staff who acted as chaperones had completed relevant training, staff did not write in the patient notes that they had provided chaperoning duties.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Data showed patient outcomes were low compared to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive care plan documented in the record was 53% which is 36% below the CCG and national average.
- The practice did not have clear oversight of their performance or position relating to QOF (Quality Outcomes Framework is the annual reward and incentive programme detailing GP practice achievement results).
- We saw some evidence that audit was in place.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice had employed a pharmacist to undertake medication reviews. However there needed to be a more proactive approach because a number of high risk medication reviews had not been completed.
- A large number of staff had not had appraisals or personal development plans although we were told that this would be completed by September 2017.
- Staff were accessing training on blue stream and through CCG learning events.

Are services caring?

Requires improvement

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

- Survey information we reviewed showed that some patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Patient information notices regarding local services were seen in the reception area although they were randomly placed and patient confidentiality cards were not available at reception desk.
- We saw staff treated patients with kindness.
- We spoke to four patients and two PPG members who told us they felt cared for and that most staff were helpful.

Summary of findings

- The practice employed a Chinese interpreter to support this large group of patients and there was a Carers Information board in the waiting area.
- The practice did not hold a register of patients with a learning disability although they did have a Carer's Register, however it was reported that nobody had overall responsibility to keep this register up to date.

Are services responsive to people's needs?

The practice is rated as inadequate for providing responsive services.

Inadequate

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, the practice had carried out a Chinese Cancer Event in response to a high number of Chinese patients and there were plans in place to repeat a similar event for the large number of Asian patients.
- The practice had satisfactory facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence showed the practice responded to issues raised. Learning from complaints was shared with staff although the practice did not keep details of investigations they had undertaken.
- Some patients we spoke with said they found it easy to make a GP appointment with urgent appointments available the same day. However telephone access was reported as poor with patients unable to get through without delay. In addition patients reported that they were unable phone the practice between 12 noon to 3.30 pm and that it was easier to walk in and get appointment.

Are services well-led?

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

Inadequate

- The practice was in the process of developing a vision but not all staff were aware of this or their responsibilities in relation to it. Most staff felt supported by management but at times they weren't sure who to approach with issues.
- The practice did not have effective governance or management processes in place to drive and develop quality services. For example they did not have oversight of their performance or position relating to QOF and staff were told to contact the duty doctor for patient queries relating to specialist areas such as diabetes. Staff were not using current emergency guidance or promoting patient confidentiality.

Summary of findings

- Practice meetings had been recently implemented (using a rota system to ensure that all staff groups were represented) to improve communication across the wider practice team.
- All staff had received inductions but a large number of staff had not had appraisals or personal development plans although on the day of inspection we were told that this would be completed by September 2017.

Summary of findings

The six population groups and what we found

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

Older people — **Inadequate**

The practice is rated as inadequate for the care of older people.

- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people were mixed. The practice was 1% above the local and national average for the care given to patients with an irregular heartbeat. Outcomes for those with heart failure was 2% below the local and 3% below the national average.

People with long term conditions — **Inadequate**

The practice is rated as inadequate for the care of people with long term conditions.

- Nursing staff had lead roles in long term condition management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was 6% below the CCG average and 4% below the national average.
- Practice nurses were trained to perform blood tests to regulate the dose of blood thinning medication required for patients.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people — **Inadequate**

The practice is rated as inadequate for the care of families, children and young people.

- On the day of inspection we were shown a training matrix which identified that staff had undertaken safeguarding updates.
- Immunisation rates were comparable for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age appropriate way and were recognised as individuals.

Summary of findings

- The practice's uptake for the cervical screening programme was 71.5%, which was 4% below the CCG and national average.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students) — Inadequate

The practice is rated as inadequate for the care working age people (including those recently retired and students).

- The practice offered on-line services as well as a range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable — Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people.
- The practice offered longer appointments for patients with a learning disability.
- The practice worked with other health care professionals in the case management of vulnerable patients.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia) — Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people living with dementia).

- 72% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is 13% below the local average and 12% below the national averages.
- 53% of those patients experiencing poor mental health had their care reviewed in a face to face meeting in the last 12 months, which is 36% below the local and 35% below the national averages.

Summary of findings

- The practice worked with multidisciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice carried out advance care planning for patients living with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff we spoke with had a good understanding of how to support patients with mental health needs and those living with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published on 7 July 2017 showed the practice was performing below local and national averages. 236 survey forms were distributed and 99 were returned. This represented 1% of the practice population.

- 45% found it easy to get through to this surgery by phone compared to a CCG average of 69% and a national average of 71%.
- 73% were able to get an appointment to see or speak to someone the last time they tried (CCG average 82%, national average 84%).
- 73% described the overall experience of their GP surgery as fairly good or very good (CCG and national average 85%).
- 62% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG and national average 77%).

As part of our inspection we asked for CQC comment cards to be completed by patients prior to the inspection. We received 10 comment cards some of which were positive about the standard of care received. Comments included 'the nurse is always helpful' and 'staff are very friendly and polite'. Several less positive comments related to poor access to the practice by telephone and the lack of routine appointments We spoke with six patients during the inspection. Feedback from patients about their care was mostly positive. All patients said they were happy with the care they received and thought staff tried their best.

The Mathews Practice Belgrave

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Inspector. The team included a GP specialist advisor and a two CQC Inspectors.

Background to The Mathews Practice Belgrave

The Mathews Practice Belgrave is located close to Sheffield city centre. It has a branch surgery at White Lane in Gleadless on the outskirts of Sheffield although we did not visit this site on the day of inspection. The practice provides services for 9,515 patients under the terms of the NHS General Medical Services contract. The practice catchment area is classed as within the group of the fifth more deprived areas in England. The age profile of the practice population is similar to other GP practices in the area.

The practice has two male GP partners, one salaried GP and two long term locum GPs. They are supported by a three practice nurses, three healthcare assistants, a practice manager and a team of reception and administrative staff. The practice is open between 8 am to 6 pm on Monday to Friday. Between the hours of 12.30pm to 3.30pm telephone calls to both sites are answered by the out-of-hours service although reception is open. Appointments are available from 8am to 10.30am every morning and from 3pm to 5.30pm with GPs daily at both sites. Extended hours appointments are offered from 7am with the practice nurse and healthcare assistant daily. Pre-booked appointments are available with a GP on Saturday morning. Patients had access to the services provided through the Prime Ministers Challenge Fund to hub sites across the City up until 10pm during evenings and weekends.

A phlebotomy service with the healthcare assistant is available daily and the practice also employs a pharmacist. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them. Both premises are owned by the partners. The White Lane site is a converted residential property with two parking spaces to the front of the building. All patient facilities are on the ground floor. The Matthews Practice Belgrave is a purpose built building with all patient facilities on the ground floor and a minor surgery suite.at one end of the practice. There is a large car park to the side and back of the practice. When the practice is closed calls were answered by the out-of-hours service which is accessed via the surgery telephone number or by calling the NHS 111 service.

Why we carried out this inspection

We undertook a comprehensive inspection of the Mathews Practice Belgrave on 1 November 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe and well led services and was placed into special measures for a period of six months.

We also issued a warning notice to the provider in respect of safe care and treatment, good governance and receiving and acting on complaints and informed them that they must become compliant with the law by March 2017. We

Detailed findings

undertook a follow up inspection on 6 June 2017 to check that action had been taken to comply with legal requirements. The full comprehensive report on the November 2016 and June 2017 can be found by selecting the 'all reports' link for The Mathews Practice Belgrave on our website at www.cqc.org.uk.

We undertook a further announced comprehensive inspection of The Mathews Practice Belgrave on 24 July 2017. This inspection was carried out following the period of special measures to ensure improvements had been made and to assess whether the practice could come out of special measures.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as Sheffield Clinical Commissioning Group to share what they knew. We carried out an announced visit on 24 July 2017. During our visit we:

- Spoke with a range of staff (three GPs, two practice nurses, one practice manager, four non-clinical and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Inadequate

Are services safe?

Our findings

At our previous inspection on 1 November 2016, we rated the practice as inadequate for providing safe services as patients were at risk of harm. This was because: the documentation, communication and learning from significant events was not in place; systems and processes relating to infection control had not been implemented; the safeguarding of children and vulnerable adults required a review and the GP locum pack needed updating to assist GP locums in their work.

Some of these arrangements had not improved when we undertook a follow up inspection on 24 July 2017. The practice is still rated as inadequate for providing safe services.

Safe track record and learning

The provider had reviewed the system for reporting and recording significant events and implemented a significant event policy. Most staff were aware of the new process and told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). In addition to this, a book had been introduced at both the main site and the branch surgery for staff to record 'minor' events which was reviewed weekly by the practice manager. This was introduced to encourage staff to report 'minor' issues that they had previously tended to resolve there and then and not report. We saw that administrative staff were reporting concerns through the books on reception. However practice nursing staff we spoke to told us they had not yet used the book. From the sample of six documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings from March 2017 where significant events were discussed. Although a new significant event process had been implemented, this system was not proactive enough to ensure that events did not re-occur and no review date was in place to monitor and track progress. We saw some evidence that lessons were shared and action was taken to improve safety in the practice. For example, we reviewed six incidents reported since our last inspection in November 2016, which related to a number of issues for example, the inappropriate allocation of tasks. We saw minutes of monthly practice meetings, from March 2017, where incidents had been discussed. In addition, practice meetings had been implemented (using a rota system to ensure that all staff groups were represented and could attend) so that lessons could be learned and communicated across the wider practice team. For example, we were told that staff had recently had the opportunity to reflect upon their knowledge and understanding of responding to emergency situations following a recent incident on the premises. The practice managed safety alerts and updates through a cascade system to the relevant staff groups and we saw general alerts on a notice board in the staff room.

The incident recording form captured the investigations undertaken as part of the review and referred to reporting incidents to other organisations if required. If things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had had reviewed the arrangements to keep patients safe and safeguarded from abuse which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff on the practice intranet. The safeguarding policy outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for both child and adult safeguarding. We noted since our last inspection that the safeguarding lead had gained the appropriate permissions on the patient record system to view safeguarding alerts. GPs attended safeguarding meetings when possible although these were not minuted. Staff demonstrated they understood their responsibilities in relation to safeguarding and during the inspection we were shown a new training matrix which identified all staff practice staff had undertaken safeguarding updates. GPs were trained to child safeguarding level three.

- All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). On the day of inspection we noticed that the chaperone policy was available on the notice boards in treatment rooms to alert patients to the availability of chaperones. However the policy was in small print, consisted of several paragraphs and was obscured by a list of telephone numbers in one room. Therefore it was not easy to read and only able to be accessed once in the room. In addition, chaperone staff did not write in the patient notes that they had provided chaperoning duties.
- On the day of inspection we observed the premises at the Belgrave site to be clean and tidy. The processes for the standards of cleanliness and hygiene had been reviewed since the October 2016 inspection. For example, cleaning schedules were kept on the back of the doors for each room. Staff signed a sheet to record all the schedules were completed. The record captured issues and concerns that required follow up. Audits of areas cleaned were documented and reported verbally to the practice manager. The written documentation for the control of substances hazardous to health had been improved and related to product guidelines for the management of such substances.
- The arrangements had been reviewed for cleaning equipment and substances hazardous to health were appropriately and safely stored.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw that a rota system was in place for all the different staffing groups to ensure enough staff were on duty. The practice had a number of GP vacancies they were recruiting for and often GP locums were used to provide care to patients. Since our last inspection in November 2016, the practice told us that they had carried out an audit to monitor the amount of locums they had used. In addition, the locum GP pack had been improved and updated however the pack still needed to include further details to assist GP locums in their work such as a checklist for home visits and referral guidelines.
- The practice manager and a healthcare assistant were the infection prevention and control clinical leads. There was an infection control protocol in place and we were shown a training matrix which identified that all staff had received up to date training since the October 2016 last inspection. Infection Prevention and Control audits had been completed for since the last inspection at both sites however, some actions were outstanding with no date for completion. For example there were ripped chairs in some consulting rooms and heavily marked light pull switches in staff toilet facilities at the Belgrave site.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice mainly kept patients safe (including obtaining, prescribing, recording, handling, storing and disposal). Processes were in place for handling repeat prescriptions.
- The practice had employed a pharmacist to undertake medication reviews but a number of these had not taken place. On the day of inspection we noted that two out of six patients receiving high risk repeat medications had not been proactively reviewed.
- The practice had two refrigerators on site and we found the arrangements for the monitoring of medicines requiring refrigeration was not safe. For example, in one refrigerator the alarm temperature was set incorrectly (2-9 rather than 2-8). In the other refrigerator only one thermometer, a data logger, was in place and the average temperature was being recorded rather than the minimum and maximum temperatures.
- Blank prescription forms and pads were securely stored, and there were systems in place to monitor blank prescription form use to enable these to be tracked through the practice. The use of prescription pads was monitored.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow practice nurses to administer medicines in line with legislation. However, we noted they had been signed by the practice nurse

and not authorised by the practice representative. The practice manager told us a GP had reviewed them and had time scheduled after the inspection to sign them. The practice have confirmed since the inspection that this has been done. However, these issues should have been dealt with more proactively and been under regular review.

- Healthcare assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately
- We reviewed personnel files and found most of the required recruitment checks had been undertaken prior to employment. For example, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However we noted that there was not satisfactory evidence for conduct of staff in previous employment. For example there was no application form or CV in place for a member of the practice nursing team.
- The provider employed locum GPs directly and there were systems in place to check whether they met requirements such as having current professional indemnity, registration with the appropriate professional body, DBS checks and were on the GP National Performers' list. (The National Performers' list provides a degree of reassurance that GPs are suitably qualified, have up to date training and have passed other relevant check such as with the Disclosure and Barring Service).

Monitoring risks to patients

Some risks to patients were assessed.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the staff corridor which identified local health and safety representatives. A risk assessment of the premises had been undertaken in August 2016 and areas were identified for further action in the short to mid-term business plan.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- A fire risk assessment had been completed in August 2016 at both premises and actions were being taken to address the areas for improvement identified.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room. Oxygen was available on the premises with adult and children's mask and first aid kit and accident book were available.
- On the day of inspection the practice did not a defibrillator on the premises because it was off site being repaired. No alternative arrangements were in place and no risk assessment had been completed to identify how risks to patients would be managed during this time. We observed that emergency equipment was being reviewed on a monthly rather than on an at least weekly basis as per the Resuscitation Council (2015) guidelines..
- Emergency medicines were accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. The practice had provided stocks of Atropine (a drug which is given before anaesthesia to decrease mucus secretions) and rectal Diazepam (which is used to treat fits) since our last inspection. However there was no stock control of things in the doctors bag (e.g. urine test strips expired in November 2015)
- Staff were using out of date resuscitation guidelines in their emergency boxes. For example, 2005 guidelines were seen in the resuscitation box and 2008 guidelines in the anaphylaxis box. (The most recent resuscitation guidelines were updated in 2015).

Inadequate

Are services safe?

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 1 November 2016, we rated the practice as requires improvement for providing effective services because: a range of data showed patient outcomes were lower compared to the local and national averages; there was little evidence that audit was driving quality improvement in patient outcomes; multidisciplinary working was generally informal and record keeping was limited or absent; dates and records of staff training sessions were not held and practice nursing staff had not received an appraisal within the last 36 months.

Some of these arrangements had improved when we undertook a follow up inspection on 24 July 2017 however the practice is now rated as inadequate for providing effective services.

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice received the weekly Sheffield Clinical Commissioning Group updates which were passed to the practice manager or assistant practice manager. This information was then sent to the relevant lead in the practice for that area. For example, medical device alerts were sent to the pharmacist, patient safety alerts were sent to the lead GP and general alerts were sent to the relevant groups and/or placed on a bulletin board in the staff room.

Management, monitoring and improving outcomes for people

The practice did not have oversight of their performance or position relating to QOF 2016/2017 (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 94.3% of the total number of points available with 10.4% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2015/16 showed:

- Performance for diabetes related indicators was 6% below the CCG average and 4% below the national average.
- Performance for mental health related indicators was 28% below the CCG and the national average.
- Performance for blood pressure checks in those with high blood pressure was 12% below the CCG and 11% below the national average.
- Prescribers at the practice had been identified as prescribing 7% of antibiotic items that are Cephalosporins or Quinolones compared to the local and national average of 5%.

The practice had employed a new member of nursing staff to support the team in undertaking long term condition reviews which are performed for those patients with poor mental health and those requiring blood pressure checks. The staff member was currently being supported by an experienced practice nurse from another GP practice. We were told that the practice was currently reviewing their staffing arrangements and had advertised roles for GPs and an advanced nurse practitioner to meet the needs of patients with long term conditions.

On the day of inspection we saw evidence that medication audits had been commenced. For example we saw evidence of one two cycle audit and one single cycle audit. One of the audits related to the prescribing and usage of Cephalosporin's (any of a group of broad-spectrum antibiotics resembling penicillin) which had been identified as an issue at the previous inspection. The other two cycle audit related to the use of Statins (lipid lowering drugs) to improve patient compliance. In order to continue to improve patient outcomes the practice need to maintain and develop their audit programme.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.

Inadequate

Are services effective?

(for example, treatment is effective)

- Staff training had been improved since our last inspection in November 2016 and we were shown a matrix which identified that all staff had undertaken safeguarding, fire safety awareness, basic life support and information governance training. Staff had access to and made use of e-learning training modules and in-house training.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of some staff were identified through a system of appraisals, meetings and reviews of practice development needs. Most staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, clinical supervision and facilitation and support for revalidating GPs and nurses. Six out of twenty four staff had not received an appraisal within the last three years. This had been identified as part of the business plan and we were told that the remaining staff would be appraised by September 2017.
- A number of GP locum staff worked at the practice. The locum introduction pack had been updated since our last inspection to include details for the local child and adult safeguarding teams. The GP safeguarding lead was named and there were contact details in the pack. There were links to practice policies and procedures, however we noted that there was no checklist for home visits or referral guidelines within the locum induction pack.
- The practice had employed a pharmacist to undertake medication reviews but a number of these had not taken place. On the day of inspection we noted that two out of six patients receiving high risk repeat medications had not been proactively reviewed.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff were using different sets of hand written notes rather than a specific practice protocol to review chest pain guidance when ruling out emergency symptoms over the telephone

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Other health care professionals were invited to to the bi-monthly clinical meetings where care plans were routinely reviewed and updated for patients with complex needs. We were told at the last inspection that attendance at these meetings from other health professionals was not consistent and the practice manager was still working with the teams to improve attendance.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

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

- Patients receiving palliative care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

- Midwives and community nurses held a number of clinics at the practice. These included: diabetic, COPD

Inadequate

Are services effective?

(for example, treatment is effective)

(chronic obstructive pulmonary disease), asthma and warfarin (blood thinning) monitoring clinics. Healthcare assistants provided health checks and the practice had an on-site counselor who provided cognitive behavioural therapy (CBT)

- Two counsellors held a weekly clinic offering talking therapies to patients .and a health trainer to offer general health advice. Staff told us the services were popular with patients particularly to assist them to make healthy life choices.

The practice's uptake for the cervical screening programme was 71.5%, which was 4% below the CCG and national average. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice identified the uptake of the screening programme was low for certain ethnic groups and planned to address this by using information in different languages and ensuring a female sample taker was available.The practice also identified low take up of national screening programmes for breast cancer in females between 50 to 70 years old. The uptake was 58% which was lower than the local average of 77% and the national average of 73%. Bowel screening was comparable to local and national averages.

A cancer information event for breast and cervical screening was being planned in collaboration with Macmillan and Sheffield Clinical Commissioning Group to support Asian patients. The practice was working in collaboration with Sheffield University to develop a patient exercise programme alongside the introduction of Health Trainer Café's. A Virtual Ward had been set up working in partnership with Age UK and the Clinical Commissioning Group (CCG) to manage and avoid hospital admissions for the local population.

There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example childhood immunisation rates for the vaccinations given to under two year olds ranged from 81% to 94%, compared to the CCG average of 86% to 95% and five year olds from 92% to 95% compared to the CCG average of 88% to 96%.Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

At our previous inspection on 1 November 2016, we rated the practice as requires improvement for providing caring services because data from the national GP patient survey showed patients rated had mixed views for several aspects of care.

These arrangements had not improved when we undertook a follow up inspection on 24 July 2017. The practice is rated as requires improvement for providing caring services.

Kindness, dignity, respect and compassion

- We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and they could offer them a private room to discuss their needs. The practice had introduced a ‘green card’ system to enable patients to alert staff if they wanted to discuss a sensitive issue. This was done to improve and maintain patient and information confidentiality in the reception area. However, on the day of inspection we noted that the ‘green cards’ were not easily accessible for patients to request at the Belgrave site.
- As part of our inspection we asked for CQC comment cards to be completed by patients prior to the inspection. We received 10 comment cards some of which were positive about the standard of care received. Comments included 'the nurse is always helpful' and 'staff are very friendly and polite’. Several less positive comments related to poor access to the practice by telephone and the lack of routine appointments.We spoke with six patients during the inspection. Feedback from patients about their care was mostly positive. All patients said they were happy with the care they received and thought staff tried their best. Results from the national GP patient survey (2017) were mixed for consultations with staff and there was little or no improvement on the 2016 data:

- 81% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 78% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 86%.
- 88% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 81% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 86%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 78% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%.
- 91% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 91%.
- 92% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- Following this feedback the practice had plans in place to employ more GPs and customer service training had been implemented for reception staff. In addition, practice meetings had been implemented (using a rota system to ensure that all staff groups were represented and could attend) so that lessons could be learned and communicated across the wider practice team. For example, we were told that staff had recently had the opportunity to reflect upon their knowledge and understanding of responding to emergency situations following a recent incident on the premises.
- **Care planning and involvement in decisions about care and treatment**
- On the day of inspection, patients told us they mostly felt involved in decision making about the care and treatment they received. They also told us they felt

Are services caring?

listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. No improvement was seen on the data from the 2017 survey. For example:

- 70% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 70% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%
- 91% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG and national average of 90%.
- 86% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.
- The practice provided facilities to help patients be involved in decisions about their care:
- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice also employed an interpreter who spoke Chinese and was developing links with the local Chinese Community Centre.
- We saw information leaflets were available in easy read format and available in different languages.
- **Patient and carer support to cope emotionally with care and treatment**

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.
- Information about support groups was also available on the practice website. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 68 patients as carers (0.9% of the practice list). Written information was available to direct carers to the various avenues of support available to them. On the day of inspection we were shown a carer's register however we were told that nobody took the lead in overseeing this. There was a Carers Information board in waiting area. The practice did not keep a register of patients with a learning disability.
- Staff told us that if families had experienced bereavement, their usual GP may contact them to provide advice on how to find a support service.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 1 November 2016, we rated the practice as inadequate for providing responsive services because: although the practice had reviewed some of the needs of its local population, there was not a plan in place to secure improvements for all of the areas identified; there were inconsistencies dealing with complaints and no evidence that learning from complaints had been shared with all staff and access to a named GP and continuity of care was not always available quickly,

Some of these arrangements had improved when we undertook a follow up inspection on 24th July 2017. However, the practice is still rated as inadequate for providing responsive services.

Responding to and meeting people's needs

The practice had reviewed its patient profile and had used this understanding to meet the needs of its population. For example, we were told that there were plans in place to support an Asian Cancer Event in response to the high number of Asian patients. We were told that CRISIS teams were in place to address mental health needs locally.

- The practice offered appointments with the practice nurses and healthcare assistants from 7 am on weekdays for working patients who could not attend during normal opening hours.
- Pre-bookable appointments were available with a GP on Saturday mornings rotating between each site.
- There were longer appointments available for those who required them.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- A GP performed a weekly 'surgery' at the local care home where patients resided to promote continuity of care and support the staff to care for the residents. We contacted the nursing home who told us they were satisfied with the level of care provided.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and referred to other clinics for vaccines available privately.
- Both sites had a portable hearing loop and telephone interpretation services available.
- The practice employed a Chinese speaking interpreter, a receptionist spoke Urdu and a GP spoke Arabic to meet the needs of the patient population.
- Some patients told us they were able to get appointments and that the practice offered telephone call back if there were no appointments available.

Access to the service

The practice was open between and Monday 8am to 6pm Monday to Friday. Between the hours of 12.30pm to 3.30pm telephone calls to both sites were answered by the out-of-hours service although reception was staffed. Appointments were available from 8am to 10.30am every morning and from 3pm to 5.30pm with GPs daily at both sites. Extended hours appointments were offered from 7am with the practice nurse and healthcare assistant daily. Pre-booked appointments were available with a GP on Saturday morning at alternate sites. Patients had access to the services provided through the Prime Ministers Challenge Fund to hub sites across the City up until 10pm during evenings and weekends. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. Results from the national GP patient survey (2017) showed that patient's satisfaction with how they could access care and treatment was notably lower than local and national averages. For example,

- 62% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and the national average of 76%.
- 45% of patients said they could get through easily to the practice by phone compared to the CCG average of 69% and the national average of 71%.
- 73% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 82% and the national average of 84%.
- 61% of patients said their last appointment was convenient compared with the CCG average of 79% and the national average of 81%.
- 56% of patients described their experience of making an appointment as good compared with the CCG average of 70% and the national average of 73%.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- 55% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 56% and the national average of 58%.

The practice had identified access as part of their mid to long term business action plan. Staff told us that they had a high number of patients who did not attend for their appointment and that they often had empty appointment slots at the end of the day. Feedback from patients suggested that it was difficult to get through to the practice by telephone to cancel an appointment. The practice were still considering different telephone systems to improve access for patients both to book and cancel appointments. A solution had not yet been agreed at the time of our inspection. Some patients we spoke with said they found it easy to make a GP appointment with urgent appointments available the same day. However telephone access was reported as poor with patients unable to get through without a long delay. In addition patients reported that they were unable phone the practice between 12 noon to 3.30pm and that it was easier to walk in and get appointment.The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The system in place for handling complaints and concerns had been reviewed since our last inspection to reflect recognised guidance and contractual obligations for GPs in England. The complaint policy identified specific response times for the different stages of the process. There was a designated responsible person who handled all complaints in the practice and GPs were no longer responding personally to complaints made against them. Details of complaint investigations were not kept and it was not always clear how complaints were investigated and by whom.We saw that information was available to help patients understand the complaints system. We looked at seven complaints received since our last inspection. Complaints were more consistently handled. Information about how to complain was available and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff although the practice did not keep details of investigations they had undertaken. For example, a complaint was made about the incorrect prescribing of a medication and the short response did give some detail how they would prevent this happening again. Written complaints responses now included the details for the Parliamentary Health Service Ombudsman for the person to contact if they were not happy with the practice response. the practice did not keep details of investigations they had undertaken.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 1 November 2016, we rated the practice as inadequate for providing well-led services because: although most staff felt supported by management they did not feel supported by the partners; the practice had a number of policies and procedures to govern activity, but some of these were incomplete or missing and not all staff had received regular performance reviews.

We issued a warning notice in respect of these issues although we found arrangements had not improved when we undertook a follow up inspection of the service on 24 July 2017. The practice is still rated as inadequate for being well-led.

The practice was developing a vision to deliver quality care and promote good outcomes for patients. Some staff that we spoke to were not aware of the vision nor their responsibilities in relation to it.

Governance arrangements

- Some staff were aware of their own roles and responsibilities. Some GP's and nurses had lead roles in key areas. For example, the practice manager and practice nurse now took the lead for infection prevention and control and there were GP leads in place for child and adult safeguarding. Some staff seemed unclear who took the lead for long term conditions and were referred to locums for advice.
- Practice specific policies were still being implemented and had been made available to all staff on the practice internet. The majority of the policies and procedures had been updated and reviewed since our last inspection. For example, the clinical governance policy was now complete and separate from the information governance policy. The complaints policy had been updated to include response time frames and staff roles and responsibilities. The practice still used a number of GP locums and the GP locum pack had been updated to provide information on how to access policies and procedures.
- There was some improvement in the understanding of the performance of the practice however the practice did not have oversight of their performance or position relating to QOF. For example the practice were not able to gain access to their most recent data
- There were gaps in the provision of some long term conditions reviews in particular those relating to diabetes. This had been identified as part of the business action plan and the practice had introduced diabetic clinics to improve patient monitoring. Staff told us they opportunistically reviewed patients with long term conditions when they attended the practice.
- On the day of inspection we saw evidence that two medication audits had been undertaken. One audit related to the prescribing and usage of Cephalosporin's (any of a group of broad-spectrum antibiotics resembling penicillin) because high prescribing of these medications had been identified as an issue at the previous inspection. The other audit related to the use of Statins (lipid lowering drugs) to improve patient compliance. The practice did not have an audit programme in place.
- Since our last inspection monthly staff meetings had been introduced to provide staff with the opportunity to learn about the performance of the practice.

Leadership and culture

The practice did not have a satisfactory approach to leadership and there was a lack of joined up governance to keep patients safe. This related to key issues such as chaperoning, assessing emergency symptoms over the telephone, patient confidentiality and significant event reporting. The practice did not thematically review significant event analysis to ensure that events did not re-occur. Patients we spoke to told us about poor telephone access to the practice. .

There was little oversight of the practice performance or position relating to QOF 2016/2017 and the most recent data was not available. We were told that 6 out of 24 performance reviews had been carried out and the remaining 18 would be completed by September 2017.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This had recently included staff discussion about notifiable safety incidents.

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

Are services well-led?

Inadequate

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

- The practice manager had more recently kept written records of verbal interactions as well as written correspondence. However, the practice had not kept details of the investigations that were undertaken as a result of complaints.

We were told that practice meetings were being held on a monthly basis. Staff told us they had the opportunity to raise any issues with the practice manager and felt confident and supported in doing so. Most staff said they felt valued and supported, particularly by the practice manager.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.

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

The practice had gathered some feedback from patients through the patient participation group (PPG). The PPG had met once since our last inspection and were due to meet again in September 2017. The group told us that they still did not feel fully engaged with the practice but they had met with the new practice manager. The group felt they had a lot to offer the practice and would welcome the opportunity further engage and take part in future practice events. The PPG had produced quarterly newsletters for patients with the support of the assistant practice manager.

The practice had gathered feedback from staff through meetings and discussions. However, some staff told us they did not feel involved and engaged to improve how the practice was run. The practice were making an attempt to improve staff retention through staff incentives including pay and benefits. In addition all staff were given a birthday gift voucher and a staff party event was being planned for September.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe Care and Treatment** Care and treatment must be provided in a safe way for service users **How the regulation was not being met** Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: **12(2)(g)** • A member of nursing staff was using Patient Group Directions (PGD) to administer medications and although signed by the nurse these had not been authorised. • The procedure for the storage of medications requiring refrigeration were not in line with current guidance. Cold chain arrangements in practice refrigerators were not set or monitored within the correct limits. For example in one refrigerator the alarm temperature was set incorrectly (2 degrees Celsius to 9 degrees Celsius rather than 2-8 degrees Celsius). In the other refrigerator only a data logger, was in place and the average temperature was being recorded rather than the minimum and maximum temperatures. There was no second thermometer. **12(2)(e)** • The provider did not make sure that equipment was suitable for its purpose or properly maintained. For example, we observed that emergency equipment was being checked on a monthly rather than on an at least

Requirement notices

- weekly basis as per the Resuscitation Council (2015) guidelines; the contents of GP emergency bags were not being regularly checked for example, urine test strips expired in November 2015.
- On the day of inspection, emergency equipment was not available to meet people's needs. The practice did not a defibrillator on the premises because it was off site being repaired and no alternative arrangements were in place and a risk assessment had not been completed to identify how risks to patients would be managed.

12(2)(a b)

- The practice did not implement up to date guidance to take appropriate action if there was a clinical or medical emergency. For example staff were using resuscitation guidelines which were out of date. We found different sets of guidelines from (2005) in the resuscitation box, and guidelines from (2008) in the anaphylaxis box. The most current Resuscitation Council guidelines are 2015.

This is in breach of Health and Social Care Act 2008 (RA) Regulations 2014: Regulation 12 (1) Safe Care and Treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 19 Fit and Proper Persons Employed** Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons The registered person's recruitment procedures did not ensure that potential employees had the necessary qualifications, competence, skills and experience before starting work. In particular: **How the regulation was not being met:** **19(1)(a)**

This section is primarily information for the provider

Requirement notices

- When checking staff recruitment files we noted that there was not satisfactory evidence for conduct of staff in previous employment. For example there was no application form or CV in place for a member of the practice nursing team.
- Not all staff had a Personal Development Plan or appraisal

This is in breach of Health and Social Care Act 2008 (RA) Regulations 2014: Regulation 19 (1) Fit and Proper Persons Employed.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance** **How the regulation was not being met** **17(2)(a)** • The practice did not have a joined up approach in relation to a number of governance issues to keep patients safe for example, chaperoning arrangements required a review because staff did not write in the record that they had chaperoned. • We did not see a protocol to help administrative staff to assess emergency symptoms over the telephone for example, the chest pain guidance was unclear and staff were following hand written notes. • The practice did not have effective governance or management processes in place to improve patient access to quality services. • The practice did not have effective governance or management processes in place to ensure that patients were kept safe in relation to: emergency guidance, patient confidentiality or significant event reporting. • Patients reported poor telephone access to the practice. • Continuous quality improvement activity needed a review. There was little oversight of the practice performance or position relating to Quality Outcomes Framework. • Not all staff had received regular performance reviews. We were told that 4 out of 20 performance reviews had been carried out and the remaining 16 would be completed by September 2017 This is in breach of Health and Social Care Act 2008 (RA) Regulations 2014: Regulation 17 (1) Good Governance.