Blyth Road Medical Centre

Quality Report

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

Ratings

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

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 Blyth Road Medical Centre on 24 March 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, caring, responsive and well led services. They are rated good for effective services. They also required improvement for providing services for all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents.
- Near misses were not reported or investigated.
- Information about safety was recorded, monitored, reviewed and addressed but not shared widely with staff.
- Data showed patient outcomes were average or above for the locality and the practice had a plan in place to improve diabetic care for patients
- Some audits had been carried out and we saw some evidence they were driving improvement in performance to improve patient outcomes.
- Patients said they were mostly treated with compassion, dignity and respect and mostly involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Urgent appointments were usually available on the day they were requested. Patients reported difficulty getting through to the practice by telephone to make an appointment.
- The practice had a number of policies and procedures to govern activity, but these were not always followed by staff.
- The practice had not proactively sought feedback from staff.

The areas where the provider must make improvements are:

Summary of findings

- Ensure near misses are reported and investigated
- Ensure an infection control audit is completed and action plan implemented in accord with the findings.
- Ensure the practice keeps a medicine stock list which is checked regularly.
- Risk assess the storage of medical records to comply with security and record retention schedules
- Ensure all staff follow practice policies and procedures

In addition the provider should:

- Perform a risk assessment for the provision of oxygen on the premises
- Review how learning from incidents and complaints is shared with all staff in a timely manner
- Review leadership arrangements
- Review the length of GP appointments to ensure they meet the differing needs of the patient population

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where they should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents. Near misses were not reported or investigated. When things went wrong, reviews and investigations took place. Lessons learned were communicated to administrative staff on an informal basis. Although some risks to patients who used the services were assessed and managed we noted an infection control audit had not been completed within the last 12 months. We found an expired medicine in the nurses room.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Practice staff had identified diabetic care was just below the average and had a plan in place to address this. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams and kept records of the meetings.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made. Data showed patients rated the practice lower than others for some aspects of GP care. The majority of patients said they were treated with compassion, dignity and respect. However, not all felt listened to by GPs. Information was available to help patients understand the services available to them but patients reported it was not organised in themes.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Feedback from patients reported GP appointments often did not run to time. GPs offered five minute appointment slots and patients' could request a double appointment if needed. A 15 minute GP appointment slot was available for annual health reviews. Access to a named GP and

Summary of findings

continuity of care was not always available quickly, although urgent appointments were usually available the same day. The practice was equipped to treat patients and meet their needs. Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a statement of purpose and staff told us the main priority was to deliver good quality care. There was no documented leadership structure for medical and nursing staff. Staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity, but were not always followed by practice staff.

Governance issues were discussed at the monthly clinical meetings attended by medical and nursing staff. We were told an annual meeting was held to discuss themes from incidents and complaints. Practice staff worked closely with the patient participation group (PPG) to get feedback from staff. All staff had received an induction to their role and annual appraisal review. We were told whole practice meetings were not held regularly.

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

Requires improvement

The practice is rated as requires improvement for the care of older people. Whilst we found evidence some aspects were good the practice was rated requires improvement for providing safe services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nationally reported data showed that outcomes for patients were met for conditions commonly found in older people. Patients over 75 were offered an annual health check. However, the practice was not responsive to the needs of older people as five minute appointments slots were offered with the GP which did not suit all of the patients needs. If they wanted more time with the GP patients' had to request a double appointment. Patients' told us they sometimes felt rushed by the GP. Home visits were available if needed.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long term conditions. Whilst we found evidence some aspects were good the practice was rated requires improvement for providing safe services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Nursing staff and a GP had lead roles in long term condition management. Patients at risk of hospital admission were identified as a priority. Fifteen minute appointments were available for annual reviews. Home visits were available when needed. The reviews with nursing staff were co-ordinated to streamline the process if the patient had more than one long term condition.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. Whilst we found evidence some aspects were good the practice was rated requires improvement for providing safe services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Patients told us that children and young people were treated in an age-appropriate way. Appointments were available outside of school hours but limited to five minutes unless a double

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appointment was requested. The premises were suitable for children and babies but did not have adequate room to accommodate more than one pushchair. We saw good examples of joint working with midwives.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for working age people (including those recently retired and students). Whilst we found evidence some aspects were good the practice was rated requires improvement for providing safe services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. Appointments were available on Thursday evenings until 8.10pm and Friday mornings from 7.15am. Patients could book appointments and request repeat prescriptions online. Patients told us sometimes they were not listened to by the GP and often waited past their appointment time to be seen.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for people whose circumstances may make them vulnerable. Whilst we found evidence some aspects were good the practice was rated requires improvement for providing safe services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 93% of these patients had received a follow-up. A double appointment could be booked at the patient's request. A drugs and alcohol counsellor held a clinic in the practice once a week.

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)

Requires improvement

The practice is rated as requires improvement for people experiencing poor mental health (including people with dementia). Whilst we found evidence some aspects were good the practice was rated requires improvement for providing safe services and being well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group. A double

Summary of findings

appointment could be booked at the patient's request. Patients told us they often waited a long time after their appointment time to be seen. Eighty one percent of people experiencing poor mental health had received an annual physical health check. A mental health practioner held a clinic in the practice once a week. The practice worked with multidisciplinary teams in the case management of people experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia.

The practice signposted patients who experienced poor mental health to various support groups and voluntary organisations including Mind which is a charity organisation who provide advice and support to empower anyone experiencing a mental health problem. They had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have experienced poor mental health.

Summary of findings

What people who use the service say

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from January 2015 and the NHS Friends and Family Test (FFT) of 161 patients undertaken by the patient participation group. The evidence from these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, We noted 149 patients reported they were likely or extremely likely to recommend the practice to a friend of family member

The practice was below the CCG average for its satisfaction scores on consultations with doctors with 78% of practice respondents saying the GP was good at listening to them compared to the CCG average of 89%. With 79% saying the GP gave them enough time compared to the CCG average of 89%.

We received 32 completed CQC comment cards to tell us what patients thought about the practice. They contained mainly positive views about the service experienced. Patients reported the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Several comments were less positive stating they were not given enough time by the GPs and three CQC comment cards reported patients' were not listened to by GPs.

We also spoke with seven patients on the day of our inspection. Most told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They told us they were not satisfied with the access to the telephone appointments system. They confirmed they had made many attempts to get through to the practice as the telephone line was continually engaged especially first thing in the morning. This was aligned to 53% of respondents to the national GP patient survey who reported it easy to get through to the practice by telephone compared to the local average of 75%.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure near misses are reported and investigated
- Ensure an infection control audit is completed and action plan implemented in accord with the findings.
- Ensure the practice keeps a medicine stock list which is checked regularly.
- Risk assess the storage of medical records to comply with security and record retention schedules
- Ensure all staff follow practice policies and procedures

Action the service SHOULD take to improve

In addition the provider should:

- Perform a risk assessment for the provision of oxygen on the premises
- Review how learning from incidents and complaints is shared with all staff in a timely manner
- Review leadership arrangements
- Review the length of GP appointments to ensure they meet the differing needs of the patient population

Blyth Road Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, GP specialist advisor, a practice manager specialist advisor and two CQC inspectors.

Background to Blyth Road Medical Centre

Blyth Road Medical Centre is located in the village of Maltby on the outskirts of Rotherham. The practice provides personal medical care services for approximately 6,237 patients under the terms of the nationally agreed NHS General Medical Services contract. The practice catchment area includes Micklebring, Braithwell, Stainton, Hellaby, Maltby, Stone, Hooton Levitt, and parts of Ravenfield, Bramley, Carr and Firbeck. The area is classed as within the group of the fourth most deprived areas in England. The age profile of the practice population is broadly similar to other GP practices in the Rotherham District Clinical Commissioning Group (CCG) area. However the practice does have a higher number of female patients registered between 40 to 49 years old than the local area.

The practice is owned by the three male GPs who each work six to seven clinical sessions per week. They are supported by three practice nurses, one healthcare assistant, ten administrative staff and one practice manager.

The practice is open weekdays from 8am to 6.30pm with extended opening on Thursday evenings until 8pm and Friday mornings from 7.15am. GP appointments are available between 8.30am to 11am and 3pm to 5.30pm Monday to Wednesday. Thursday from 8am to 11am and 6.30pm to 8pm. Friday from 7.15am to 11am and 4pm to 6.30pm. The practice is closed one Thursday afternoon per month for planned training sessions. The practice nurses offer appointments for diabetes, asthma, family planning, vaccines and immunisations. A midwife, mental health practioner and a drug and alcohol counsellor hold clinics at the practice each week. Out of hours care is provided by Rotherham out of hours service and is accessed via the surgery telephone number and listening to the message or calling the NHS 111 service.

Blyth Road Medical Centre is registered to provide; diagnostic and screening procedures, family planning, maternity and midwifery services and the treatment of disease, disorder or injury from 8 Blyth Road, Maltby, Rotherham, S66 8JD.

Why we carried out this inspection

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

Please note 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed information we hold about the practice and asked Rotherham Clinical Commissioning Group (CCG) and NHS England to share what they knew. We carried out an announced visit on 24 March 2015. During our visit we spoke with three GPs, two nursing staff and five members of the administrative team. We also spoke with seven patients who used the service and reviewed 32 patient CQC comment cards where patients shared their views and experiences of the service.

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

Staff at the practice used a limited range of information to identify risks and improve patient safety. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents. For example, there was a system in place to report incidents and share national patient safety alerts. Near misses were not reported or investigated. We were told learning from incidents was shared with all practice staff at an annual meeting.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We were told 'significant events' were discussed at the monthly clinical meeting. Administrative staff told us they did not attend these meetings and they would receive feedback from the practice manager. There was some evidence the practice had learned from these and the findings were shared with relevant staff.

Staff told us they would complete an incident form and send it to the practice manager. We tracked eight incidents and saw the records. Five of the incidents reported by practice staff related to the actions of other organisations. These were referred back to the relevant organisation for further investigation. The remaining three incidents we saw were completed in a timely manner. Evidence of the action taken was documented as a result. For example we were told how the procedure for prescribing medicines had been reviewed and updated following an incident where a patient was given the same medicine twice. We reviewed incident reports and briefings to staff to remind them to check the patient record before they administered a medicine. Staff had initialled the briefing to acknowledge they had read it. It was documented in the incident record the patient's family had been contacted and informed of the incident. The notes recorded an apology had been given and the relative informed of actions taken.

Staff described situations which were considered a 'near miss' which were not formally reported or investigated. For example, we were told a patient's condition had deteriorated in the practice and emergency treatment was required. Staff attended to the patient until the emergency services arrived. Staff told us they did not report the event. We discussed the importance or reporting 'near misses' with the practice nurses in order to identify learning and to offer support to staff who were involved.

National patient safety alerts were disseminated by the practice manager to practice staff via email and also a copy printed off and stored in staff trays. Staff initialled the alert to record they had seen it. Staff we spoke with were able to give examples of recent alerts they had read. Staff told us alerts were discussed at monthly clinical meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed all staff had received relevant role specific training for safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, properly document safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. We noted there had not been any recent safeguarding incidents reported under local procedures.

One of the GPs was the lead for safeguarding vulnerable adults and children. They had been trained to level 3 in safeguarding and could demonstrate they had skills to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the patient electronic records. This included information to make staff aware of any relevant issues when patients attended for appointments. For example those patients who were being supported by the mental health practioner who held a clinic at the practice once a week. GPs appropriately used the required codes on the electronic patient record system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The safeguarding GP was aware of vulnerable children and adults records.

Requires improvement

Are services safe?

Practice staff told us they would attend child protection case conferences and serious case reviews where appropriate. Reports were sent to the practice if staff were unable to attend.

We were told practice staff held monthly multidisciplinary meetings with a community matron and district nurses. Other health and social care staff attendance could be requested if needed. The practice had a procedure to follow up children who persistently failed to attend appointments at the practice which was actioned by administration staff.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. This action is necessary to ensure staff could observe any procedures were carried out in an appropriate manner). The healthcare assistant and administration staff had undertaken training as chaperones. We were told the chaperone process was not always documented in the patient notes. We reminded GPs of the importance of documenting the chaperone process.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators. We found they were stored securely and were only accessible to authorised staff. There was a clear policy which ensured medicines were kept at the required temperatures, this described the action to take in the event of a potential failure. The practice staff followed the policy.

We asked to see the documented processes to check medicines were within their expiry date and suitable for use. We were told the practice did not keep a stock list of medicines stored. One medicine we checked in the cupboard had expired. We reported to this to staff and observed it was disposed of in line with waste regulations.

Data from the electronic Prescribing Analysis and Costs (ePACT) for 2013-14 indicated staff at the practice prescribed a higher number of antibacterial (43%) and hypnotic medicines (73%) compared to other practices in the area (28% for both). We were told this had been identified and the practice was working with the CCG Pharmacist Lead. The practice had signed up to the prescribing quality incentive scheme with the CCG. We were shown where they had made some improvements in prescribing. For example the practice prescribed vitamin D and calcium supplements for all those patients who needed it.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We observed prescriptions being given to patients without patient identity checks performed. Staff told us this was because they knew the patient. We reported this to the registered manager who told us staff would be reminded to follow the practice procedure.

Blank prescription forms were handled in accordance with national guidance and kept secure at all times.

Cleanliness and infection control

Practice staff appeared to be doing the best they could to keep the practice clean and tidy. The floor covering in the reception area was heavily stained in areas of high foot traffic. Staff told us three floor mats were down on the reception floor to prevent pools of water collecting from foot traffic when it was wet outside.

We saw there were cleaning schedules in place for the whole surgery. The schedules did not record when the cleaning took place. Patients we spoke with told us they mostly found the practice to be clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had recently undertaken further training to enable them to provide advice on infection control. They had also been trained to deliver staff training which we were told had not yet been scheduled. Not all staff had received role specific infection control training. We asked to see an infection control audit and were told one had not been completed in the last 12 months. We were told this was in progress.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, guidance when to use personal protective equipment including disposable gloves, aprons and coverings. Staff were able to describe how they would use these to comply with the infection control policy. Reception staff told us how they would deal with specimens from patients. We

noted and practice staff told us there was no personal protective equipment available in reception. There was a protocol for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff toilets. Patient toilets did not display hand hygiene notices. We observed one patient toilet had a hand pull light switch cord which was heavily marked in an area due to continual use. We noted there were no sanitary disposal units in staff or patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We were shown the procedure for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records the current certificate had expired in August 2014. We were told it was scheduled to be tested in the near future. Monthly water temperature checks were being completed in line with the policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers which indicated the last testing date of October 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example the blood testing machine and the fridge thermometer.

Staffing and recruitment

Records we looked at contained some evidence recruitment checks had been undertaken prior to employment. For example, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) had been completed. We were shown the recruitment policy which set out the standards to follow when they recruited clinical and non-clinical staff. We noted this was not always followed as a recent staff member recruited only had one reference and pictorial proof of identification was not recorded.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staff groups to ensure enough staff were on duty. There was also an arrangement in place for members of staff, which included nursing and medical staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We were shown records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

We were shown systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, staffing, dealing with emergencies and equipment. There was also a health and safety policy.

Health and safety information was displayed for staff to see and there was an identified health and safety representative. Individual areas of risk were identified and logged separately. For example, we saw risk assessments for the electrical sockets in the practice. They were checked regularly to ensure child proof covers were in place.

The appointment system allowed a responsive approach to risk management. For example, when there were no appointments available for people who requested an urgent appointment, the GP would be informed and phone the patient back.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Oxygen was not available in the practice. We asked to see a risk assessment to why the practice did not have oxygen. We were told one had not been completed. All members of staff we spoke with knew the location of the equipment and records confirmed it was checked regularly.

Requires improvement

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew the location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the emergency medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the utility companies if power was lost.

The practice had carried out a fire risk assessment this included actions required to maintain fire safety. Records showed most staff were up to date with fire training and the fire alarm was tested weekly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told they were discussed at the clinical practice meetings and new guidelines were disseminated. The minutes of these meetings were hand written. We found from our discussions with the GPs and nurses they completed thorough assessments of patients' needs in line with NICE guidelines. We were told clinical pathways within the electronic patient record were used for some conditions.

A GP told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We were told this supported all staff to continually review and discuss new best practice guidelines.

National data showed the practice was slightly above referral rates to secondary and other community care services for all conditions. The GPs we spoke with used national standards for the referral of conditions which included elective muscular- skeletal conditions and patients with suspected cancers referred and seen within two weeks. We were told this was an area the practice focused the clinical audits on to monitor their performance.

Discrimination was avoided when making care and treatment decisions. Interviews with the GP showed the culture in the practice was patients were cared for and treated based on need. The practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to monitor the practice progress. Staff told us this was shared at clinical meetings and the practice manager told the administrative team.

We were shown four clinical audits undertaken in the last year. The GPs and nurses told us clinical audits were often linked to referrals to secondary care or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). Two of the audits were completed and they were able to demonstrate the changes resulting since the initial audit. We were shown an audit of patients being referred to a dermatology clinic. The audit highlighted practice staff had referred more patients to the dermatology clinic than other practices in the area. Following the audit the patients' notes were reviewed and the top tips for referral revisited by the GPs. We were told the audit review would demonstrate whether patients were being appropriately referred to dermatology and the top tips guidance followed.

We were told staff used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 79% of patients with asthma had an annual review compared to 71% for the CCG average. The practice met all the minimum standards for QOF in asthma and chronic obstructive pulmonary disease (COPD). The practice was an outlier for diabetes clinical targets. This had been identified by staff and they were working together to improve diabetic reviews. The practice uptake for the seasonal flu vaccine was three percent higher than the local average for those patients over 65 years old. They were 11% higher than the local average for patients aged between six months and 65 years old. Eighty one percent of people experiencing poor mental health had received an annual physical health check compared to 77% CCG average.

Medical and nursing staff described how, as a group, they reflected on the outcomes being achieved and areas where this could be improved at clinical meetings. Staff told us clinical supervision sessions tended to be informal and were not formally documented. We were told how they would access external supervision and support through

Good

Are services effective?

(for example, treatment is effective)

their clinical networks. For example staff accessed the local Desmond centre for advice about diabetic conditions. Staff spoke positively about the culture in the practice to offer clinical advice and support.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked patients who received repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. The GP told us after they received an alert, they would review the use of the medicine in question. If they continued to prescribe it they would outline the reason why they decided this was necessary.

Staff were working towards the gold standards framework for end of life care. They had a register of palliative care patients and held monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the CCG. This was a process of evaluating performance data from the practice and compared it to similar surgeries in the area. This benchmarking data showed the practice had improved its prescribing trends.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We noted not all staff had recent infection control training. We were told places on this course were limited. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation had been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals and had objectives in place. During our interviews with staff we were told the practice was proactive in how they provided training and funding for relevant courses. For example a member of the nursing team was being supported to complete a respiratory diploma.

Nursing staff performed defined duties and were able to demonstrate they were trained to fulfil these duties. For example, administration of vaccines, cervical cytology and child health clinics. Those with extended roles would see patients with long-term conditions such as asthma, COPD, and coronary heart disease and they were able to demonstrate they had appropriate training to fulfil these roles.

We were told where poor performance had been identified appropriate action would be taken following the practice's policy. Managers told us they did not have any recent examples of when the policy had been used.

Working with colleagues and other services

Staff at the practice worked with other service providers to meet patient's needs and manage those patients with complex needs. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. We were shown the policy outlining the responsibilities of all relevant staff in how they passed on, read and acted on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system worked well. The practice told us about a recent incident where communication from the hospital contained incorrect information. This had been identified by practice staff and reported to the hospital. Staff told us they had been informed of the event and reminded to check all patient correspondence thoroughly.

Practice staff supported the avoidance of unplanned hospital admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We were told five percent of the practice population had a care plan in place to avoid unplanned hospital admission. The practice held separate quarterly palliative care team meetings to discuss the needs of complex patients, for example those with end of life care needs.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was

Good

Are services effective?

(for example, treatment is effective)

a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice used the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported this system was easy to use.

The practice had signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff who treated patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Staff told us they had recently moved to this system and checks had yet to be carried out to assess the completeness of these records and identify any shortcomings.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties with respect to these. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. staff told us they had received updates during a practice training session for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards but had not completed a knowledge assessment.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice had reviewed 76% of dementia care plans in last year. The practice had a high dementia diagnosis rate of 94% compared to the local CCG average of 68%. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Staff told us they had not needed to use restraint in the last three years. They were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

The practice staff offered NHS Health Checks to all its patients aged 40 to 75 years. The practice held a register of those patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed 84% had received a check up in the last 12 months The practice had also identified the smoking status of 94% of patients over the age of 16 and actively offered smoking cessation clinics to 83% of these patients which was slightly lower than the CCG average of 92%.

The practice's performance for cervical smear uptake was 86%, which was better the CCG average of 78%. Staff told us all patients who did not attend any screening programme were followed up by practice staff.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was comparable for the CCG, and again there was a clear policy for following up non-attenders by the practice nurse. The practice also offered 24 hour blood pressure and spirometry recordings.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from January 2015 and the NHS Friends and Family Test (FFT) of 161 patients undertaken by the patient participation group. The evidence from these sources showed patients were satisfied with how they were treated and this was with compassion, dignity and respect. For example, We noted 149 patients reported they were likely or extremely likely to recommend the practice to a friend of family member.

The practice was below the CCG average for its satisfaction scores on consultations with doctors with 78% of practice respondents saying the GP was good at listening to them compared to the CCG average of 89%. Seventy nine percent stated the GP gave them enough time compared to the CCG average of 89%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 32 completed cards which contained mainly positive views about the service experienced. Patients described the service as good and most staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Several comments were less positive stating they were not given enough time by the GPs and three CQC comment cards reported the GP did not listen. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed patients had difficulty talking to reception staff due to the reception glass window. Patients had to bend down to talk through an opening at the bottom of the window. We were told a new sliding glass window was ready for installation. We observed conversations with reception staff could be heard in the waiting area. The practice switchboard was located away from the reception window in the reception room. Staff told us if a patient requested privacy they would find an empty treatment room or use the pharmacy consulting room.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The national GP patient survey information we reviewed showed patients responded positively to questions about nurses involving them in planning and making decisions about their care and treatment. For example, the survey showed 92% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments which was above the CCG average of 89%. Respondents also rated the nurses above the CCG average of 69% with 74% reporting the nurse involving them in decisions about their care. The GP scores were slightly lower than the CCG average of 83% for explaining tests and treatments which was 77%. GPs were four percent lower than the CCG average for involving the patient in planning and making decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us their health issues were discussed with them and they mainly felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by the majority of staff. Three patients told us they felt rushed during consultations with GPs and it was difficult to make an informed decision about the choice of treatment available. Patient feedback on three of the comment cards was aligned with these views.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke with on the day of our inspection and the comment cards we received were positive about the emotional support provided by practice staff. For example, they highlighted staff responded compassionately when

Requires improvement

Are services caring?

they needed assistance and provided support when required. We were told by one patient how they were supported by staff to manage their condition by referral to a support service.

Notices in the patient waiting room provided information how to access a number of support groups and organisations. Notice boards contained a variety of information and there were posters on the walls. Some patients told us there was a lot of information and it was not 'organised' in themes. We noted some of the NHS choose well posters were out of date and reported this to practice staff.

The electronic patient record alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them and how to register with a local carer's group. The practice website contained a link to the NHS Choices carers resource. We were told carers were routinely offered the flu vaccination.

Staff told us if families had experienced bereavement, they would be offered details of bereavement services and could also book appointments with either the nursing staff or a GP.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and where service improvements needed to be prioritised.

The practice had an active Patient Participation Group (PPG) who told us they were actively recruiting new members. The practice implemented a suggestion for improvement following feedback from the PPG. For example patients could register for a reminder service so their appointment details could be sent to them via a text message. We were told this was to try and reduce the number of appointments where patients did not attend. Minutes of the PPG meetings were available on the practice website and on a notice board in the reception area.

An drug and alcohol counsellor and a mental health practioner held a clinic in the practice once week. Staff told us patients spoke very highly about this service and the appointments booked up quickly. The midwife held a regular weekly clinic in the practice and health visitors were contacted as required.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. A british sign language interpreter could be booked for those patients who needed it. We saw notices in the waiting room area informing patents these services were available.

The practice premises comprised of a two storey detached building which contained an independent pharmacy, reception area, five treatment rooms and patient toilet facilities on the ground level. Staff offices, kitchen facilities and a staff area were located on the first floor. The practice was accessed via ground level and all of the services for patients were on this floor. Two manual entrance doors to the practice were wide enough to accommodate wheelchairs and prams. We noted one door opened internally and the other externally with little space in between the two doors once open. Reception staff told us they knew the patients who may need assistance and would help them by holding the doors open for them.

The reception area was to the front of the practice with external windows. Reception staff used a room opposite the pharmacy which contained fixed height workstations. The reception window faced the waiting area for the pharmacy. Patients in the practice waiting area could not be observed by reception staff. The waiting area contained two U shaped seating areas. We observed the area would only accommodate one wheelchair or pram at a time without blocking the walkways. We observed pushchairs being left outside on the small garden area to the front of the practice. This was not a secure area or covered from the weather elements. Patients were called to the treatment rooms in person or via a patient call display screen. We observed patients sat in the U shaped area nearest the window could not see the patient call display screen. Patients told us they got up each time they heard the system bleep to see if it was their turn. Nursing staff told us they greeted their patients in the reception area.

Patient toilet facilities were large enough to accommodate those needing assistance. Baby changing facilities were located in the patient toilet. We observed there were no sanitary disposal facilities in the patient or staff toilets. The first floor contained a meeting area, kitchen facilities and offices for practice staff.

The practice actively supported patients who had been on long-term sick leave to return to work. Staff told us they could be referred to local support groups such as Rotherham counselling group. The practice website contained further information for patients who were off work and referred to fit notes for returning to work.

Access to the service

GP appointments are available between 8.30am to 11am and 3pm to 5.30pm Monday to Wednesday. Thursday from 8am to 11am and 6.30pm to 8pm. Friday from 7.15am to 11am and 4pm to 6.30pm. Nurse appointments were available from 8.30am to 6pm during the week.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients rang the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information for the out-of-hours service was provided to patients.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Longer nurse appointments were available for patients who needed them. Practice staff told us GPs offered five minute appointment slots. Patients' could request a double appointment if necessary.
Fifteen minute appointments slots were available for those patients' requiring annual health reviews. We were told every fifth GP appointment was blocked to enable them to catch up and for clinics to run to time. Four CQC comment cards reported a long wait in the practice after the appointment time to be seen. Two patients we spoke with told us they often waited five to ten minutes after their appointment time to be seen. However 75% of respondents to the national GP patient survey reported they waited 15 minutes or less to be seen which was higher than the CCG average of 69%.

Staff told us if a patient or their carer requested a home visit the request was passed to the GP on call to contact the patient and decide the appropriate course of action. Staff told us home visits were offered to those patients who needed them. Practice staff told us they encouraged patients to come to the practice where the proper equipment and facilities were available.

Appointments could be made via the telephone, in person or online. The patients we spoke with on the day of our visit told us they were not satisfied with the access to the telephone appointments system. They confirmed they had made many attempts to get through to the practice as the telephone line was continually engaged especially first thing in the morning. This was aligned to 53% of respondents to the national GP patient survey who reported it easy to get through to the practice by telephone compared to the local average of 75%. Patients told us there was often a long wait to make an appointment with the GP of their choice. Staff at the practice told us they acknowledged some patient's preferred to see a specific GP. If a patient requested an urgent appointment they would be offered one with the on call GP. Patients told us they appreciated the online appointment booking and repeat prescription requests as it saved them ringing the practice.

The practice's extended opening hours on Thursday evenings until 8pm and Friday mornings from 7.15am was particularly useful to patients with work commitments. Patients' told us they appreciated this as it did not disrupt their working day.

Listening and learning from concerns and complaints

Staff at the practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We noted complaint investigations and responses did not comply with the practice policy as some staff told us they responded to their own complaints.

We saw information was available to help patients understand the complaints system and included information on the website and on leaflets in the practice. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint within the last year about the practice.

We looked at five written complaints received in the last 12 months and found they were dealt with in a timely way. Three involved another agency leading on the complaint. The other two complaint responses addressed the areas of concern, detailed the investigation which took place and the findings. An apology was given where appropriate. We noted and fed back response letters should include details of the health service ombudsman for the complainant to pursue further if they felt necessary. Practice staff told us they did not record feedback from verbal complaints. We were told anyone wishing to provide feedback to the practice verbally their details would be taken and passed to the practice manager to contact them. We were told an annual meeting to discuss complaints and incidents had been held recently. Staff we spoke to could not recall any themes or learning identified from the meeting.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a statement of purpose and staff spoke positively about working at the practice. They told us the main priority was to deliver good patient care. Staff placed high value on understanding the needs of patients and continuity of care. They said there was a supportive and friendly culture among the staff.

We were told the practice had completed the workforce planning tool with the CCG. Business meetings were held regularly between the practice manager and GPs.

Governance arrangements

Staff at the practice had a number of policies and procedures in place to govern activity and these were available to staff on their electronic desktops. We looked at 10 of these policies and procedures which had been reviewed every second year. We noted and fed back some of the procedures were not being followed by practice staff. For example confirming patient details when giving out prescriptions.

We noted staff at the practice were not following the procedure for registering new patients at the practice. We observed staff taking photocopies of proof of identity and there was no schedule for how this information would be kept. This was reported to the registered manager who told us the procedure would be immediately reviewed. We noted patient paper notes were stored in unlocked cabinets in the staff area. Access to this area was not secured during normal practice hours.

Some staff were unclear as to who took the lead roles. For example, not all staff knew who the lead for infection control was. A GP partner was the lead for safeguarding and most staff we spoke with told us this.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for Blyth Road Medical Centre showed it performed slightly below national standards. The practice achieved 88% of its QOF points for the year 2013-14 which was lower than the CCG average of 94%. We were told one GP took the lead for QOF.

Staff at the practice had undertaken patient reviews and clinical audits. They did not have an on going programme of clinical audit. However they could demonstrate where improvements had been made following an audit. For example referral to the dermatology clinic.

The practice had identified some risks which were collated on a risk log. For example we saw non slip mats had been placed in the reception area during wet weather as pools of water collected on the floor. Individual risks were annually assessed or as and when but not all staff were aware of the risk assessments process.

Leadership, openness and transparency

We asked to see a documented leadership structure for staff at the practice. We were told it was not documented. Nursing staff told us the nominated nursing lead was the person who had been at the practice the longest.

Nursing and administrative staff told us they felt supported by management. The practice held monthly clinical meetings where governance issues were discussed. Administrative staff told us they did not have regular team meetings. The practice did facilitate staff training one afternoon every second month. Staff told us they found these sessions useful as most staff attended.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures and the induction policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG) of fourteen members and were actively trying to recruit more. They met on a bi-monthly basis and had gathered feedback from patients through patient surveys. We looked at the results of NHS Friends and Family Test (FFT) of 161 patients undertaken by the patient participation group in December 2014 and January 2015. We noted 149 patients reported they were likely or extremely likely to recommend the practice to a friend of family member. Other themes identified related the

Are services well-led?

Requires improvement

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

difficulty getting through to the practice on the telephone and the availability of appointments. We were told the results had yet to be discussed to formulate a plan of action.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with management. They did this when the issue arose to the relevant manager but stated they did not always receive feedback as to the actions taken and the outcome. There were no arrangements for staff surveys.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and available within the practice.

Management lead through learning and improvement

Staff told us they were supported to maintain their clinical professional development through training and personal development. We were told all staff had a recent appraisal or clear objectives in place within the last twelve months. New staff told us how their probation period had been signed off. Staff told us the practice was supportive of training and they had staff training sessions where guest speakers and trainers attended. Staff told us about a recent session where the lead from the CCG attended to deliver a session on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found the registered person had not protected by providing safe care and treatment. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 both of which corresponds to regulation 12 (2) (f) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 This was because: 1. A recent (within the last 16 months) infection control audit had not been performed. 2. There were no sanitary disposal facilities in the staff or patient toilets. 3. No records of stock of medicines were kept. 4. An expired medicine was found in the cupboard. 5. Staff were observed giving out prescriptions without checking the identity of the patient. Regulation 12 (2) (f) (g) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found the registered person had not protected people against the risk of not providing good governance. This was in breach of regulation 20 of the

This section is primarily information for the provider

Requirement notices

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(2) (c) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This was because:

1. Patient paper records were not stored securely and unnecessary personal information was kept without a record retention schedule.

2. Near misses were not reported and investigated

3. Staff did not always follow practice policy or procedure

Regulation 17(2) (c) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.