Devonshire House

Inspection report

Devonshire House
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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 location	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Devonshire House on 12 June 2019 as part of our inspection programme.

The provider, Primary Care Doncaster Ltd (PCD), is a GP federation located in Doncaster. PCD has been commissioned to provide 160 hours per week of extended access services in Doncaster to expand routine primary care capacity. This includes 62 hours of routine pre-bookable GP appointments. These are provided at four hub sites based at local GP surgeries on Saturday mornings. They also provide 18 hours of primary care outreach services, targeting excluded and vulnerable groups.These services were part of this inspection. The remaining hours, 44 hours of same day access appointments and 36 hours of physiotherapy services, were not included in this inspection as they are subcontracted to other local providers. The provider of the service for the same day access appointments is separately registered with CQC and therefore subject to a separate inspection. The physiotherapy service is not within the scope of CQC.

Thirty-six people provided feedback about the service. All were positive about the care and treatment provided. They said they were pleased to be able to access weekend appointments and were complimentary about the staff.

Our key findings were :

- Services were organised and delivered to meet patients' needs.
- There was an effective system in place for reporting and recording significant events.
- Information about services and how to complain was available.
- Most risks to patients were assessed and managed except for infection prevention and control, provision of emergency medicines and equipment and transport of patient information and blank prescriptions.
- A register of policies and procedures which were in place to govern activity. However, not all polices, and procedures were effectively implemented.
- There was a clear leadership structure and staff felt supported by management. Feedback was proactively sought from staff and patients, which was acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish and operate recruitment procedures to ensure only fit and proper persons are employed. Ensure specified information is available regarding each person employed and that they are registered with the relevant professional body where appropriate.

(Please see the specific details on action required at the end of this report).

The areas where the provider **should** make improvements are:

- Review and risk assess procedures for transportation of blank prescriptions by staff.
- Review and risk assess transportation of patient information from the inclusion clinic to the main site.
- Review and risk assess provision of emergency medicines and equipment for inclusion clinics in line with the Resuscitation Council guidelines 2015.
- Review and improve procedures for the oversight of referrals.
- Review and improve systems to monitor that clinical outcomes and prescribing practice is in line with best practice guidelines.
- Review and improve systems to disseminate safety alerts to all members of the team including sessional and agency staff.
- Review and improve systems to monitor standards of infection prevention and control are being maintained at each site.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and second CQC inspector.

Background to Devonshire House

The provider, Primary Care Doncaster Ltd (PCD), is a GP federation located in Doncaster. PCD has been commissioned to provide 160 hours per week of extended access services in Doncaster to expand routine primary care capacity. This includes 62 hours of routine pre-bookable GP appointments. These are provided at four hub sites based at local GP surgeries on Saturday mornings. They also provide 18 hours of primary care outreach services, targeting excluded and vulnerable groups. These services are managed from the location Devonshire House and were part of this inspection. The remaining hours, 44 hours of same day access appointments and 36 hours of physiotherapy services, were not included in this inspection as they are subcontracted to other local providers. The provider of the service for the same day access appointments is separately registered with CQC and therefore subject to a separate inspection. The physiotherapy service is not within the scope of CQC.

The Saturday morning pre-bookable appointments are provided at four hub sites based at local GP surgeries on Saturday mornings, 9am to midday as follows:

- The Lakeside Practice, Askern, DN6 0HZ,
- Thorne Moor Medical Practice, Thorne, DN8 4BQ,
- Tickhill and Colliery Medical Practice Tickhill, DN11 9NA
- Conisbrough Group Practice, Conisbrough, DN12 3JW.

They provide 18 hours of primary care outreach services, targeting excluded and vulnerable groups, to three sites:

- Wharf House – Wednesday 1-4pm
- Changing lives – Thursday 1-4pm
- Conversation Club – Thursday 1-4pm

These services were part of the inspection and we visited Devonshire House and Wharf House as part of this inspection on 12 June 2019.

The provider is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, maternity and midwifery services, and treatment of disease, disorder or injury. These services are delivered from all sites.

The provider employs a team of management and administration staff who work from the main site, Devonshire House. Clinical staff, local to Doncaster, are employed on a sessional basis. Administration staff working at the hub sites are employed and managed by each hub site via a service level agreement with Devonshire House.

Information was gathered and reviewed before the inspection, for example, from stakeholders, notifications and provider information request submissions. We also gathered information on the day of the inspection from people who had used the service, interviewing staff, and observations and review of documents.

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

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

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

Requires improvement

Are services safe?

We rated the service as requires improvement for providing safe services because:

- There was a lack of evidence all staff had received the appropriate level of safeguarding training.
- There was a lack of evidence all the required recruitment checks had been undertaken.
- Provision of emergency equipment and medicine at inclusion clinics was not based on risk assessment.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse although some of these required improvements.

- Safety risk assessments were conducted. It had appropriate safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the service as part of their induction. The service had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- The service had systems in place to enable staff to work with other agencies to support patients and protect them from neglect and abuse. Staff told us what steps they would take to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. They had not had to make any safeguarding referrals since the service commenced in October 2018.
- The staff employed were local to the Doncaster area and Primary Care Doncaster Limited (PCD) was responsible for providing level 3 safeguarding training for all local practices. Staff were required to upload their safeguarding training certificates to the e-rostering tool electronically before being offered shifts. Evidence of the appropriate level of safeguarding training was not available for all staff, including clinicians. However, we identified that once the expiry date of the training had passed the training certificates were no longer available to view on the agency web site. Some gaps had been identified in their training records during their review process. They had subsequently developed a staff matrix to consolidate staff records into one place and were in the process of checking training records to assure themselves all staff had received up to date training appropriate to their role.
- A recruitment policy and procedure was in place and staff checks were carried at the time of recruitment. However, we were not assured all recruitment checks had been undertaken. For example, staff were employed directly via an e-rostering platform and staff uploaded information onto this electronic platform. The contract the service had in place with the organisation providing the e-rostering service indicated staff should only be able to book shifts through the website once pre-determined criteria were met in relation to documentation required. The service also held some paper records although practice in this area was not consistent. For example, we reviewed electronic and paper records of staff who had recently been employed. The service was not able to evidence relevant professional registration for a nurse and evidence of references and immunity status for all staff prior to employment. We were told that, whilst they were employed, the nurse, for whom registration information was not available, had not yet completed any shifts for the service. We were assured this would be checked before the nurse was offered a shift.
- Disclosure and Barring Service (DBS) checks were undertaken where required. (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). A written risk assessment had not been completed in relation to information on one DBS we saw. The management were aware of the content on the DBS and was able to describe the action taken in relation to this to minimise risk although this was not recorded in the persons file.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was a system to manage infection prevention and control (IPC). For example, there was a policy and procedure to support good practice which was provided to staff. Service level agreements were in place with hub sites for the management of IPC and clinical waste. Cleaning schedules had been provided for the inclusion clinics and IPC audits had been undertaken and provided to the manager at the host venues. However, we noted at one site the cleaning schedule provided by PCD was not in use and the room used did not appear on the internal cleaning schedule. The staff were able to describe the cleaning routine in preparing the room for use by PCD staff and the room appeared clean.

Requires improvement

Are services safe?

- The service ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were service level agreements in place for hub sites in relation to maintenance of equipment. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example, sepsis.
- Equipment for the management of medical emergencies was provided by the host practice at the hub sites as part of the service level agreement. Equipment for assessment and management of medical emergencies was not provided at the inclusion clinics. A written risk assessment had not been completed to support this decision.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover potential liabilities. However, some arrangements for this were not clearly understood by managers on the day of inspection and additional information was provided to us after the inspection to clarify arrangements for advanced nurse practitioners.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. However, following an incident where a referral had been delayed the service had reviewed their procedures to ensure the patient's own practice had received this. We observed actual practice did not reflect the written procedure in relation to who undertook the task to ensure the referral had been received by the patients own practice. For example, the management thought the staff at the host practice did this but the policy said the staff at the main office would do this.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The service did not hold any medicines. The host practices at the hub sites were responsible for management of medicines under a service level agreement. Medicines for assessment and management of medical emergencies was not provided at the inclusion clinics. A written risk assessment had not been completed to support this decision.
- The service kept prescription stationery securely and monitored its use. However, we identified some prescriptions were transported by staff to inclusion clinics. A risk assessment had not been completed to support this process.
- The service had not carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. As the patients' record was closed to the service following a consultation this impacted on their ability to undertake quality audits. The service was in the early stages of developing systems to enable them to do this in conjunction with the patient's own practice.
- Staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to most safety issues.
- The service monitored and reviewed most areas of activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Requires improvement

Are services safe?

Lessons learned, and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned, and shared lessons identified themes and acted to improve safety in the service.
- The service was aware of and complied with the requirements of the Duty of Candour. A culture of openness and honesty was encouraged.
- The service had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

There was no written evidence the service acted on and learned from external safety events as well as patient and medicine safety alerts. The service did not have a mechanism in place to disseminate alerts to all members of the team including sessional and agency staff. The practice had already identified this as an area for improvement and were putting processes in place including development of a staff bulletin where this information would be included.

Requires improvement

Are services effective?

We rated the service as requires improvement for providing effective services because:

- There was a lack of evidence the practice ensured staff had received relevant training, including refresher training, for their role.
- There was a lack of evidence of quality monitoring and improvement relating to clinical outcomes.

Effective needs assessment, care and treatment

All clinicians were engaged on a locum basis. The service was in the early stages of developing systems to provide clinicians with access to information to enable them to keep up to date with current evidence-based practice. Clinicians told us they accessed this information via the internet and used patient record templates. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance.

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was involved in some quality improvement activity and had completed a six month review of the service. They had developed an action plan for improvement and were in the process of implementing this. For example, the service was limited in measuring clinical outcomes due to lack of access to patients records after a consultation, but they monitored patient experience through feedback. They had identified the limitations of the IT systems for clinical audit and were working collaboratively with practices to try to develop systems to enable clinical audits to be undertaken.

Effective staffing

We were not assured all staff had the skills, knowledge and experience to carry out their roles. However, this had been identified as an area for improvement and changes were being implemented.

- Records of skills, qualifications and training were uploaded to the recruitment website by staff. Nursing staff also completed a record of competencies which was held in staff files. We were not assured all staff had completed required training. Records showed staff whose role included immunisation and cervical cytology had received specific training, but the practice could not demonstrate if they had completed updates. For example, one nurse file had the initial cytology training certificate from 2006 but there was no record of any updates on the file. We were not assured all staff had completed the relevant level of safeguarding training for their role. Monitoring of training had been identified as an area for improvement and the process of cross-referencing training records with available data and completing a staff matrix had been implemented.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, the service collected information on referrals made from the inclusion clinics, these showed a wide range of referrals to other services. For example, drug and alcohol services, wound care services, screening and mental health services.
- Before providing treatment, doctors at the service had access to the patients' medical record. However, one day per month the doctors at an inclusion clinic did not have access to the patient record as local practices were closed and patients attending the walk-in clinic could not be booked in by their own practice to open their record. In these cases, the consulting GP would record the consultation on paper records and these were scanned to the patients practice for saving onto the patient record by staff at the main site. This area had not been risk assessed and there was no protocol to support the safe transport of patient information and transfer of information. For patients who were not registered at a practice an 'immediate and necessary' electronic record was opened.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. Provision of services in the inclusion clinics were provided at venues catering for vulnerable people such

as a homeless shelter. Both staff groups worked together to enable service provision. PCD staff also worked closely with community teams, such as community nurses, in providing shared clinics for patients. This enabled GP consultations and treatment, such as wound care, to be provided for hard to reach patients at one visit.

- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were arrangements for following up on people who had been referred urgently to other services although practice did not match the written procedures.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice, so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated the service as good for providing caring services because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Interpretation services were available for patients who did not have English as a first language.
- Patients told us through comment cards, that they felt 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.

Easy read comment sheets had been developed and were given to every patient after their consultation at an inclusion clinic. Survey data provided by the practice showed, of 2492 responses, 92% of patients rated services as good or excellent.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs

Good

Are services responsive to people's needs?

We rated the service as good for providing responsive services because:

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The needs of their patients were understood and services were improved in response to those needs. The patients were consulted about the services provided and the service was reviewing the appointment availability.
- The service had taken account of feedback relating to raising awareness of the service and offering choice to patients relating to time and location offered. An additional targeted survey showed 90%, of 83 patients who responded, were offered an appointment at a time and location convenient to them. They had also worked with staff at practices to raise awareness of the service and locations available to book patients into.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. The service had funded the development of a shared room in the homeless hostel we visited to provide a suitable environment for GP consultations. This included provision of hand washing facilities and appropriate flooring.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

The service told us they would take complaints and concerns seriously but had not received any concerns or complaints.

- Information about how to make a complaint or raise concerns was available. Each patient was given a survey to complete about the service and this included a section to tell the provider if they were unhappy with the service and offered the opportunity for someone to speak to them about their experience.
- The service did not have any information to give to patients relating to further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place.

Requires improvement

Are services well-led?

We rated the service as requires improvement for providing well led services because:

- The service lacked effective processes to monitor the provision of services by other organisations such as recruitment and infection prevention and control compliance.
- While several areas had been identified for improvement, such as clinical audit and staff training, systems to improve these areas were in very early stages of development.
- Some areas had not been risk assessed such as emergency equipment and medicines provision and transport of blank prescriptions and patient records.

Leadership capacity and capability;

- Leaders had the capacity and skills to deliver high-quality, sustainable care.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The service had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

- The service had had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.
- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them
- The service monitored progress against delivery of the strategy.

Culture

- The service had a culture of high-quality sustainable care.
- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents. There was an awareness and systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- Structures, processes and systems to support good governance and management were clearly set out, understood and mostly effective.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities
- Leaders had established policies, procedures and activities to ensure safety but did not have clear procedures to assure themselves that they were all operating as intended. For example, the service had developed a cleaning schedule for the inclusion site we visited but staff at the inclusion site were not aware of this and the PCD management had not ensured this had been implemented. The practice had a contract with an external organisation to provide an e-rostering system for staff and had developed a criteria for provision of documents that must be obtained prior to staff being able to book shifts. There was a lack of oversight by the practice to ensure all documents had been obtained. Some of the required pre-employment records could not be found such as immunisation status documents and evidence of professional registration.

Managing risks, issues and performance

- There were clear and effective processes for managing most risks, issues and performance.

Requires improvement

Are services well-led?

- There was an effective, process to identify, understand, monitor and address most current and future risks including risks to patient safety. The service had completed a six-month review and developed action plans for improvement in areas including IT provision, access, performance of clinical staff and training.
- There were some areas which required review and risk assessment relating to transport of blank prescriptions, transport of patient information and provision of emergency medicines and equipment for inclusion clinics.
- The service had some processes to manage current and future performance. Leaders had oversight of safety alerts, incidents, and complaints. Performance of clinical staff was not monitored through audits of their consultations, prescribing and referral decisions due to limitations of the IT system. The service had identified this and were in the process of developing clinical audit systems in collaboration with their partners.
- The service had plans in place for major incidents.

Appropriate and accurate information

- The service acted on appropriate and accurate information.
- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, the system of transporting patient consultation records from one inclusion clinic to the main site had not been risk assessed and a protocol to support good practice had not been developed.

Engagement with patients, the public, staff and external partners

- The service involved patients, the public, staff and external partners to support high-quality sustainable services.
- The publics', patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. The practice asked patients for their views of the service after each consultation and had surveyed practices in the use of the pre-bookable appointment system at the hubs. They were reviewing how to promote the service more widely and the availability of appointments as a result of the feedback.
- Staff were able to describe to us the systems in place to give feedback. Staff told us they would speak to the managers who they found approachable.
- The service was transparent, collaborative and open with stakeholders about performance. The practice worked closely with hub managers and met with them monthly.

Continuous improvement and innovation

- There was evidence of systems and processes for learning, continuous improvement and innovation.
- There was a focus on continuous learning and improvement.
- The service made use of internal reviews of incidents. Learning was shared and used to make improvements.
- There were systems to support improvement and innovation work. The service had been operational since October 2018. They had completed a six-month review of the service and identified areas for improvement such as IT systems, training records and clinical audit. They had improved the consultation facilities at two of the three inclusion clinics to provide an appropriate room for staff. They routinely sought the views of patients and worked with partner agencies to improve the service.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 CQC (Registration) Regulations 2009 Fees **Persons employed for the purposes of carrying on a regulated activity must be fit and proper persons.** **How the regulation was not being met:** **The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular:** • There were no records that satisfactory evidence of conduct in previous employment had been obtained. • Records showed staff whose role included immunisation and cervical cytology had received initial specific training in these areas, but the practice could not demonstrate if they had completed updates. • The practice could not demonstrate all staff had completed the required level of safeguarding training for their role. • The practice could not evidence immunity status had been obtained for staff. **The registered person had not ensured employed persons who must be registered with a professional body, where such registration is required by, or under, any enactment in relation to the work that the person is to perform. The registered person had failed to ensure such persons were registered. In particular:** • The practice could not provide evidence of relevant professional registration for all staff who required this. **This was in breach of Regulation 19(3)(4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**