# Kingsway Health Centre

## Inspection report

Unit 18
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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 | Inadequate |
|---|---|
| Are services safe? | Inadequate |
| Are services effective? | Requires improvement |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Inadequate |

# Overall summary

**This service is rated as** Inadequate **overall.**

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at Kingsway Health Centre as part of our inspection programme.

Kingsway Health Centre is provided by Stevenage Health Limited. Stevenage Health Limited is a GP federation made up of local GP practices which serves approximately 94,000 patients in Stevenage, Hertfordshire. Kingsway Health Centre provides a GP extended access service to patients registered with one of the eight NHS GP practices within the Stevenage locality. The service commenced on 1 July 2018.

Each practice has been allocated a number of appointments per week which can be directly booked into the extended access service. Appointments are available from 6:30pm to 8pm Monday to Friday and from 10am to 2:30pm on weekends. The service is available to patients of all ages under the terms of an Alternative Provider Medical Services (APMS) contract with the local Clinical Commissioning Group (CCG). APMS is a contract with the CCG for delivering primary care services to local communities.

**Our key findings were :**

- The service did not have comprehensive systems to manage risk so that safety incidents were less likely to happen.
- The provider did not have clear oversight of safety risk assessments and checks, such as health and safety, infection prevention and control, fire safety and legionella.
- The systems in place to keep people safe and safeguarded from abuse needed strengthening.
- There were no risk assessments in place for some emergency equipment and medicines not held by the service.
- The service did not have a comprehensive system in place to ensure the required recruitment checks were always carried out, including DBS checks.
- The service was unable to demonstrate how staff had the skills, knowledge and experience to carry out their roles in some cases.
- The service reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Patient feedback forms demonstrated that staff treated people with compassion, kindness, dignity and respect.
- Patient feedback forms indicated that they were able to access care and treatment from the service within an appropriate timescale for their needs.
- Structures, processes and systems to support good governance and management were not clearly set out, understood and effective.

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

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

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

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Special measures will give people who use the service the reassurance that the care they get should improve.

**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 and included a GP specialist adviser.

## Background to Kingsway Health Centre

- Kingsway Health Centre is provided by Stevenage Health Limited. The registered manager is M Banks. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
- The address of Kingsway Health Centre is Unit 18, Stevenage Leisure Park, Stevenage, Hertfordshire, SG1 3QA.
- The telephone number is 01438 313223 and the website address is www.stevenagehealth.com.
- The building is owned and managed by Hertfordshire Community NHS Trust and is in a central location in Stevenage. The building is on a single level with good access. The service is located close to the main bus terminal and train station. There is ample parking available including designated disabled parking bays.
- The service is registered with the CQC to provide the following regulated activity:
- Treatment of disease, disorder or injury.
- Kingsway Health Centre provides a GP extended access service to patients registered with the eight NHS GP practices within the Stevenage locality.
- Appointments are available from 6:30pm to 8pm Monday to Friday and from 10am to 2:30pm on Saturdays and Sundays.
- The service team consists of a manager, one administrative assistant, 16 GPs, one clinical pharmacist and minor illness nurse, four advanced nurse practitioners, seven practice nurses and eight receptionists.

**How we inspected this service**

Before our inspection, we gathered and reviewed information from the local Clinical Commissioning Group, the pre-inspection return submitted by the provider and patient feedback submitted online.

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.

Inadequate

# Are services safe?

**We rated safe as Inadequate because:**

- The provider did not have clear oversight of safety risk assessments and checks, such as health and safety, infection prevention and control, fire safety and legionella.
- The service did not have a comprehensive system in place to ensure the required recruitment checks were always carried out, including DBS checks.
- Not all electrical equipment was tested according to manufacturer's instructions to ensure the equipment was safe to use.
- The service was unable to demonstrate how clinical equipment was calibrated to ensure it was working properly.
- The service was unable to demonstrate that all staff members had received the appropriate training relevant to their roles.
- A documented risk assessment for not stocking certain recommended emergency medicines was not in place.
- The system in place to ensure all relevant staff had understood each significant event and the required action was not effective.

**Safety systems and processes**

**The service did not have clear systems to keep people safe and safeguarded from abuse.**

- The provider had some safety policies. However, at the time of inspection, the provider did not have clear oversight of safety risk assessments and checks, such as health and safety, infection prevention and control, fire and legionella. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The provider told us that these assessments were managed by the owner of the premises. Shortly after the inspection, the provider sent us a copy of a completed safety assessment of the premises and provided us with a copy of a legionella risk assessment which had been carried out in 2015. We received evidence of monthly water temperature checks.
- The service had systems to safeguard children and vulnerable adults from abuse. The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The service had a Disclosure and Barring Service (DBS) policy in place and a requirement for all staff to undertake a DBS check every three years. (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). At the time of our inspection, the service was not able to provide us with evidence of DBS checks for all clinical and non-clinical staff members. Shortly after our inspection, the service told us that the majority of staff had a DBS check in place and the service was currently awaiting confirmation from five clinicans.
- All staff who acted as chaperones had received guidance. Not all staff members who acted as a chaperone had received a DBS check and the practice had not taken any action to mitigate risks.
- The service did not have a comprehensive system in place to ensure the required recruitment checks were always carried out. We checked 11 personnel records and found gaps in each file including a lack of evidence of training and a DBS check, Three staff files did not include evidence of references being obtained. The service told us that all staff continued to work in local GP practices or had worked in a GP practice before joining Stevenage Health Limited.
- At the time of inspection, the service was unable to provide evidence of appropriate safeguarding children and adults training for all clinical and non-clinical staff members. The provider told us that all relevant staff members had been asked to provide evidence of safeguarding training by 21 October 2019.
- We found the premises to be visibly clean and tidy. However, the service was unable to demonstrate that all clinical and non-clinical staff members had completed infection prevention and control (IPC) training. An IPC audit of the premises had not been completed. The provider did participate in a user group forum for the premises. There was evidence of some discussions taking place in relation to health and safety and IPC however, it was unclear if the actions agreed had been completed or were being progressed. Shortly after our inspection, we received evidence of an IPC audit which was completed on 9 September 2019.
- The provider was unable to demonstrate how all electrical equipment was tested according to manufacturer's instructions to ensure the equipment was safe to use. We found most of the electrical

equipment did have a label attached which indicated that it had been checked within the previous 12 months, however we found portable heaters in the consultations rooms which did not have any evidence of being tested to ensure they were safe to use. The service told us that they did not own the electrical equipment available at the premises and all staff were aware of how to report any faults.

- The service was unable to demonstrate how clinical equipment was calibrated to ensure it was working properly. Shortly after our inspection, the service sent us evidence to confirm all clinical equipment had now been tested to ensure they were in good working order.
- There were systems for safely managing healthcare waste.

**Risks to patients**

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- The service lead understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. The service was unable to demonstrate if clinical and non-clinical staff members had been given guidance on identifying acutely unwell patients.
- The service was unable to demonstrate if all clinical and non-clinical staff members had received Basic Life Support training.
- The service had access to emergency equipment such as oxygen and a defibrillator and a documented process was in place to ensure this equipment was checked on a regular basis. The practice held a range of emergency medicines and a system was in place to monitor stock levels and expiry dates. The service had not completed a risk assessment to determine the range of emergency medicines held at the premises. The service did not stock a number of recommended emergency medicines, including a medicine used to treat seizures and a medicine used to treat heart failure. Shortly after our inspection the service told us that they had ordered the recommended emergency medicine and would be completing a formal risk assessment.
- The service had the required vaccination records in place for some staff members. During our inspection, we found the service was unable to confirm if a number of clinical and non-clinical staff members had received all of the required vaccinations appropriate for their role. The service was in the process of obtaining this information.
- There were appropriate indemnity arrangements in place to cover all potential liabilities. The service maintained a record of professional registration for clinical staff.

**Information to deliver safe care and treatment**

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

- From the sample of documents we viewed, we found 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 in an accessible way.
- The service had systems for sharing information with other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals to the patient's registered GP in line with protocols and up to date evidence-based guidance.

**Safe and appropriate use of medicines**

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

- The systems and arrangements for managing medicines minimised risks. Medical consumables were kept safely and were in date.
- The service kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The service had a standard operating procedure in place which included a prescribing policy. All local practices had been provided with a copy of the standard operating procedure.
- The service prescribed high risk medicines and controlled drugs as part of their operating procedure and prescribing policy. The service told us that audit of high risk medicine prescribing would be undertaken by

individual GP practices within the locality. The service explained that a mechanism was in place for practices to discuss the outcome of such audits with the service directly and no concerns or queries had been raised to date.

**Track record on safety and incidents**

The service did not have sufficient safety systems in place in some areas.

- The service had adequate fire safety equipment in place and all equipment had been serviced on a regular basis. A fire procedure was in place and there was clear fire safety information displayed throughout the premises. The alarm system and emergency lighting had been serviced within the previous 12 months. The service was unable to provide evidence of regular fire alarm testing and the service had not previously undertaken a fire drill. Not all staff members had received health and safety and fire safety training and the service did not have a trained fire marshal in place.
- Shortly after our inspection, the service sent us evidence to confirm a fire drill had taken place on 12 September 2019. We also received evidence which showed that the company responsible for maintaining and servicing the premises undertook weekly checks of the fire alarms.
- The service was able to demonstrate how external safety events as well as patient and medicine safety alerts were received and acted on. The service maintained a record of safety alerts and copies of these alerts were kept in information folders which were available in each treatment room.

**Lessons learned and improvements made**

**The service had some systems in place to learn and make improvements when things went wrong.**

- The service had a clear system in place for recording and acting on significant events. For example, a locum GP had set up an urgent two week wait cancer referral task but had not sent the task to the patients' GP practice for action. The GP was reminded to regularly check the standard operating procedure available and to follow the protocol in place for sending urgent tasks.
- The service had recorded four significant events since April 2019. Significant events were discussed at clinical meetings which were held on a quarterly basis.
- There were adequate systems for reviewing and investigating when things went wrong.
- Learning from significant events was circulated to all relevant staff members. The system in place to ensure all relevant staff had understood each significant event and the required action was not effective. We spoke to a GP who was not aware of a significant event which had occurred.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.

Requires improvement

# Are services effective?

**We rated effective as Requires improvement because:**

- The provider was unable to demonstrate how they ensured all clinical and non-clinical staff received essential training relevant to their role on a regular basis.
- The service was unable to demonstrate how staff whose role included cervical screening had received specific training and how they stayed up to date.

**Effective needs assessment, care and treatment**

**The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).**

- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate information relating to additional patient needs were shared with the patient's GP.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients.
- Staff assessed and managed patients' pain where appropriate.

**Monitoring care and treatment**

**The service was actively involved in quality improvement activity**.

- The service used information about care and treatment to make improvements. The service monitored performance and made improvements where required through the use of audits. Clinical audit was used to assess the quality of care and outcomes for patients. For example, the service had completed an audit on the appropriateness of antibiotic prescribing. As a result, the service took steps to ensure all clinicians regularly checked the latest guidelines and used the clinical templates available.

**Effective staffing**

**The service was unable to demonstrate how staff had the skills, knowledge and experience to carry out their roles in some cases.**

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) Nursing and Midwifery Council (NMC) and were up to date with revalidation.
- The service explained that they employed GPs, nurses and receptions who already worked for GP practices within the local area. However, the provider was unable to demonstrate how they ensured all clinical and non-clinical staff received essential training relevant to their role on a regular basis. During our inspection we found gaps in staff training records for areas including safeguarding children and adults, basic life support, infection prevention and control, information governance, fire safety and health safety. Up to date records of skills, qualifications and training were not maintained.
- The service was unable to demonstrate how staff whose role included cervical screening had received specific training and how they stayed up to date.

**Coordinating patient care and information sharing**

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

Requires improvement

# Are services effective?

- Patients received coordinated and person-centred care. Staff communicated effectively with other services when appropriate.
- We saw evidence of patient assessments documented in clinical records. This included care assessments, details of examinations carried out, symptoms and details of ongoing care agreed with the patient.
- There were clear arrangements for submitting instructions to the patients GP practice for referral and further investigation. Patient consent was requested prior to all consultations in order to share details of the consultation and any medicines prescribed with the patients registered GP. The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- Before providing treatment, the clinician ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.

**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. The service had a range of information available to patients, including information on local support groups and guidance on self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their registered GP practice for additional support.
- Where patients needs 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.
- The service monitored the process for seeking consent appropriately.

Good

# Are services caring?

**We rated caring as Good because:**

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion.**

- Patient feedback forms collected by the service were positive about the way staff treat people. We received 40 CQC comment cards from patients which were positive about the care and treatment provided.
- The service 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.
- Patient feedback forms collected by the service were positive about the level of care and treatment provided to them.
- For patients with learning disabilities or complex social needs family, carers or professionals were appropriately involved.

**Privacy and Dignity**

**The service respected patients' privacy and dignity.**

- The service recognised the importance of people's dignity and respect.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patient feedback forms and CQC comment cards were positive about being treated with dignity and respect.

Good

# Are services responsive to people's needs?

**We rated responsive as Good 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 provider understood the needs of their patients and improved services in response to those needs. For example, the service worked closely with the local Clinical Commissioning Group and had introduced a cervical screening service in order to increase local uptake to this national screening programme.
- The facilities and premises were appropriate for the services delivered. Disabled parking spaces were available, the service had access enabled facilities.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others.

**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 a clinical professional.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The service allocated a 15 minute time slot for each consultation. Patients reported that the appointment system was easy to use.
- The service had increased the total number of hours of clinical care provided from 44 hours per week to 50 hours.

**Listening and learning from concerns and complaints**

**The service took complaints and concerns seriously and had processes in place to manage complaints appropriately to improve the quality of care.**

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had a complaints policy and procedure in place. The service had received three complaints since July 2018. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, clinicians were reminded to communicate clearly during their consultations, following a patient complaint.

Inadequate

# Are services well-led?

**We rated well-led as Inadequate because:**

- The provider had not established a governance framework to ensure adequate oversight of systems and processes in a number of areas of safety.
- The provider did not have a comprehensive process to identify, understand, monitor and address risks to patient safety.

**Leadership capacity and capability;**

**The provider did not always demonstrate it had the capacity and skills to deliver high-quality, sustainable care**

We identified issues with the general governance of the service. In particular, areas such as identifying and mitigating risks to patients were not fully assessed.

- The service did not have clear systems to keep people safe and safeguarded from abuse.
- The service did not have sufficient safety systems in place in some areas.
- Leaders at all levels were visible and approachable.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.
- The provider was unable to demonstrate how staff had the skills, knowledge and experience to carry out their roles in some cases.

**Vision and strategy**

**The service 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 where relevant.
- 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.
- There was a clear vision and set of values and staff understand their role in achieving them.

**Culture**

**The service aimed for 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 and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The service did not have processes in place for providing all staff with the development they need. Staff members had not received a formal appraisal since joining the service. Shortly after our inspection, the service told us that all staff appraisals were in the process of being arranged.
- The service actively promoted equality and diversity, however the service was unable to demonstrate if staff had received equality and diversity training.
- There were positive relationships between staff and teams.

**Governance arrangements**

**There were no clear responsibilities, roles and systems of accountability to support good governance and management in some areas.**

- Structures, processes and systems to support good governance and management were not clearly set out, understood and effective in all areas.
- The provider had not established proper procedures and activities to ensure safety and assure themselves that they were operating as intended.
- During our inspection we found weaknesses in governance arrangements and systems and processes.
- The service did not have clear oversight of safety checks and processes, such as electrical and clinical equipment, emergency medicines stock, staff vaccinations records and infection prevention and control processes.
- The service did not adequate records in place in relation to staff recruitment, including DBS checks.

Inadequate

# Are services well-led?

- The service was unable to demonstrate that all clinical and non-clinical staff members had completed the appropriate training relevant to the roles.
- Not all staff members who acted as a chaperone had received a DBS check and the practice had not taken any action to mitigate risks.
- The system in place to ensure all relevant staff were aware of significant incidents required strengthening.

Senior staff took immediate action where possible and shortly after our inspection, we received further information about the steps being taken to address the areas identified.

**Managing risks, issues and performance**

**There was no clarity around processes for managing risks, issues and performance in some areas.**

- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations and referral decisions.
- The provider had business continuity plans in place.
- There was not an effective, process to identify, understand, monitor and address risks to patient and staff safety. For example, the service did not have clear oversight of safety risk assessments, such as legionella, infection prevention and control, fire safety and health and safety.

Senior staff took immediate action where possible and shortly after our inspection, we received further information about the steps being taken to address the areas identified.

**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 service used performance information which was reported and monitored and management and staff were held to account
- 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 robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Engagement with patients, the public, staff and external partners**

**The service involved patients and external partners to support high-quality sustainable services.**

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Staff could describe to us the systems in place to give feedback.
- The service encouraged and heard views and concerns from patients and external partners and acted on them to shape services and culture.
- We saw evidence of feedback opportunities for patients and how the service responded to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.
- The service told us that they submitted regular performance reports to the local Clinical Commissioning Groups and obtained patient feedback forms. The service produced a monthly patient feedback report and patient feedback was very positive. The service had collated 1264 feedback forms between July 2018 and March 2019 and over 95% of all respondents were positive about the services provided and care and treatment received.

**Continuous improvement and innovation**

**There was some evidence of systems and processes for learning, continuous improvement and innovation however, improvements were required in some areas.**

- The system in place to ensure all relevant staff were aware of significant incidents and the learning from these events was not adequate.
- There were no systems or processes that enabled the provider to assess, monitor and improve the quality and safety of the services being provided in all areas.

Inadequate

# Are services well-led?

- The systems in place to ensure staff were appropriately trained were inadequate. The provider did not have a comprehensive system in place to ensure the required recruitment checks were in place.
- The service had piloted a cervical screening service and had received positive feedback from patients. The service was planning on continuing to offer this to patients within the locality.
- The service had introduced a direct weekend appointment booking system for the local NHS 111 service. The service allocated 32 weekend appointments per month for the NHS 111 service.
- The service was in discussions with the local CCG and GP practices about offering flu vaccinations and services to patients with long-term conditions.

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 |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**How the regulation was not being met:**<br><br>The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:<br><br>The service did not have a comprehensive system in place to ensure the required recruitment checks were always carried out, including DBS checks.<br><br>Not all electrical equipment was tested according to manufacturer's instructions to ensure the equipment was safe to use.<br><br>The service was unable to demonstrate how clinical equipment was calibrated to ensure it was working properly.<br><br>Staff vaccinations were not maintained in line with current Public Health England (PHE) guidance. There were no risk assessments in place for any staff where complete and appropriate vaccination records were not available.<br><br>The service did not stock a number of recommended emergency medicines and a documented risk assessment in relation to this was not in place.<br><br>The service did not have an effective system in place to ensure all relevant staff had understood each significant event which had occurred within the service.<br><br>This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**How the regulation was not being met:**

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

The service did not have clear oversight of safety risk assessments and checks, such as health and safety, infection prevention and control, fire and legionella.

The service was unable to demonstrate that all staff members had received the appropriate training relevant to their roles.

The service did not have a system in place to ensure staff members received an appraisal on a regular basis.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.