Petersfield Surgery

Inspection report

70 Petersfield Avenue
Romford
RM3 9PD
Tel: 0170834710

Date of inspection visit: 15 and 23 June 2023
Date of publication: 12/07/2023

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Good overall. This is the first comprehensive inspection of this service.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires Improvement

We carried out an announced comprehensive inspection at Petersfield Surgery access service on 15 and 23 June 2023, as part of our inspection programme.

At this inspection we found:

- At this inspection we identified some of the gaps in recruitment, training, clinical scope of practice and clinical supervision, which the Chief Executive Officer and staff had identified and were working towards improving but these were either not implemented or embedded at the time of the inspection.
- At the time of the inspection clinical audits had not been carried out regarding staff prescribing and referral decisions to ensure clinical staffs competency.
- The service had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the service learned from them and improved their processes.
- The Federation routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

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

Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider should make improvements are:

- Have assurances that all staff are trained to the appropriate level of safeguarding training.
- Review the complaints procedure and enable complaints to be investigated by a member of staff whom is not part of the complaint

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

Our inspection team

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

Background to Petersfield Surgery

The provider of the service is Havering Health Ltd. This is a group of local GP practices who have agreed to work together to offer a health service provided by clinicians with expertise in, understanding of, and commitment to their local communities. Havering Health Ltd directors who are all local GPs with practices in Havering. Havering Health Ltd also provides a call centre for the extended access primary care hub.

The services are commissioned by the local integrated care system commissioners for the residents of Havering who are registered with a local GP practice. It is commissioned for patients who are assessed as having an urgent primary care need and supports NHS 111, A&E, GP practices and urgent care centres. The services consist of:

- The same day extended access service offered GP appointments to any patients who called the service on the same day of their call. These were available from Monday to Friday from 6pm to 10 pm Monday to Friday and from 9am to 5pm on a Saturday and Sunday. Patients could book through the call centre, which was open to book appointments on a Monday to Friday 12 midday to 9pm and on a Saturday and Sunday from 9am to 5pm. Patients who called the 111 service or attended urgent care could also be offered an appointment. The extended access service is also located at Rosewood Medical Centre, 30 Astra Close, Hornchurch.
- The enhanced access service appointments delivered general practice services, that included appointments for planned care such as vaccinations, health checks and long-term condition reviews. They were available for GP practices to book their registered patients into, and patients could also book themselves online. The appointments were available from 6.30pm and10pm Mondays to Fridays and between 9am and 5pm on Saturdays.
- Patients were referred to the spirometry services by their NHS GP. The service was available 6pm to 10pm Monday to Friday and 12pm to 5pm Saturday. The average appointment length was one hour.
- The call handling and Havering Health management team are based at Havering Health Federation at 170 Rush Green Road, Romford RM7 0JU. Clinicians were recruited and paid on a sessional basis, at the time of the inspection 20 clinicians worked at the Petersfield service, who were supported by an administration team.

Good

Are services safe?

We rated the service as good for providing safe services.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider had systems to safeguard children and vulnerable adults from abuse. The provider followed Barking & Dagenham, Havering, and Redbridge (BHR) Primary Care Safeguarding Handbook. In addition, displayed in the consulting rooms were safeguarding flow charts and contacts.
- All doctors and non-clinical staff had completed adult and child safeguarding training to the appropriate level. Staff knew how to identify and report concerns.
- The provider had carried out a review of their recruitment procedures and found that following the recruitment of the nursing staff in October 2022 they had gaps in their recruitment and training records. Such as references, qualifications, scope of practice and immunisation history. In response they had put an action plan in place in June 2023.
- The provider had carried out Disclosure and Barring Service (DBS) checks 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).
- Staff who acted as chaperones were trained for the role and had received an enhanced DBS check.
- The premises were suitable for the assessment and treatment of patients and could be expanded during peak periods of activity.

Risks to patients

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective system in place for dealing with surges in demand. Staff told us senior staff were easily identifiable and available for staff to escalate their concerns to.
- 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. The service operated a red flag system, which identified patient risk and provided the actions the call handlers had to take. For example, when a patient was suicidal, they immediately contacted the mental health team or emergency services.
- Due to the type of the services offered, patients were not prioritised for care and treatment, in accordance with their clinical need. If the call handlers believed that the patient needed to be seen urgently, they would consult with the doctors and refer the patient to the appropriate services.
- If the patient walked into the service and requested an appointment, the receptionist would ensure the doctor was aware of anyone with urgent needs.
- Staff told patients when to seek further help. They advised patients what to do if their condition got worse.
- When there were changes to services or staff, the service assessed and monitored the impact on safety.
- There was an effective system in place to manage the prevention and control of infectious disease at the service. The service manager ensured they had oversight of the management and prevention of infection control and waste at Petersfield Surgery where staff saw patients. The service followed Petersfield Surgery infection control policies and risk assessments. In addition, the staff carried out daily checks of the rooms to ensure their cleanliness. A visit to the site found it was clean and tidy. The service did not take clinical samples.
- The service had infection prevention and control assessments and policies in place for the call centre.
- Clinical equipment owned by the provider was kept in a storage box and checked daily by the reception staff prior to use and calibrated annually.

Good

Are services safe?

Information to deliver safe care and treatment.

- We reviewed ten patient clinical records and found individual care records were written and managed in a way that kept patients safe. The staff had access to the patient's GP clinical records and was able to review the patient's full medical history, identify any risks and record the appointment.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to follow up urgent referrals. The service contacted the patient's GP practice by email and by telephone to inform them of the referral, so the GP practice could ensure the patient's referral was followed up. Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

- The service had an arrangement in place to use Petersfield Surgery medical gases, emergency medicines and equipment. The manager had oversight of the medicine management standard operating procedures at Petersfield surgery and their staff checked the equipment monthly. In addition, reception staff working on site would check the oxygen and defibrator daily. The service carried out a quality review of the emergency medicines system and also put in place a weekly check of the emergency medicines.
- The service kept prescription stationery securely and monitored its use.
- The service did not hold any medicines. Staff prescribed to patients and gave advice on medicines in line with legal requirements and current national guidance.
- The prescriber had access through the patients GP records to information about the patient's current prescriptions and allergies.
- Where a patient requested a repeat prescription, depending on the type of medicine requested the doctors prescribed sufficient medicine to last until the patient's GP practice was open.
- The service was in the process of reviewing the site-specific policy Information Management of Medicines which had not been reviewed since 2015.
- The service did not use group or specific patient directions to administer medicines and the service did not administer vaccinations or any medicines that required them to ensure medicines were stored at a cold temperature.
- The clinical director explained the service had not carried out any clinical audits and at present they had only reviewed the number of medicines prescribed.
- Staff told us they had completed sepsis training.

Track record on safety

- The service manager had oversight of the Petersfield Surgery premises and environmental audit were both last reviewed in October 2022.
- The service manager had oversight of the fire risk assessment for Petersfield Surgery, which was last reviewed in July 2022 and the call handler's office last reviewed June 2023.
- The provider had information available to staff regarding a fire assembly point and an fire emergency point, and a fire marshal protocol.
- There was a system for receiving and acting on safety alerts. The clinical lead received the alerts and sent them on to the service manager, who recorded them and cascaded them to the clinicians.
- The service had a business continuity plan in place to manage any emergency incidents.

Lessons learned and improvements made

- The clinical incidents, complaints and feedback policy which was last reviewed on 30 May 2023.

Good

Are services safe?

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. The lead clinician reviewed clinical events and the service manager reviewed events that affected the service. Significant events were discussed at Thursday leadership meetings and board meetings.
- The service had a significant events log which overall demonstrated that from to January 2023 the staff had recorded 14 significant events across the provider services. This included the lack of access to the service by a wheelchair user due to a locked door, and a missed by clinicians' rare patient diagnosis, which staff had discussed and additional training had been provided.

Good

Are services effective?

We rated the service as good for providing effective services.

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 supported by clear clinical pathways and protocols.
- Clinical staff had access to guidelines from the National Institute for Health and Care Excellence (NICE) and used this information to help ensure that people's needs were met. For example, staff had access to the spirometry diagnostic pathway for chronic obstructive pulmonary airways disease and asthma diagnosis.
- The extended same day service carried out face to face, online and telephone appointments by the doctor. Call handlers asked patients what their symptoms were, which were recorded on the patient record system and patients were then booked into the next available appointment.
- The service had not fully implemented the scope of practice for all clinical staff working in the enhanced service. However, we were told the lead clinician had spoken with the staff to establish their roles and the clinical records system had alerts about what patients the clinical staff were competent to carry out a consultation for. In addition, the supervisor would review the appointments to ensure that they were appropriate for the member of clinical staff.
- When staff were not able to make a direct appointment to the service for the patient, the call handlers followed a clear referral process and offered the patient a clear explanation.
- The service used a red flag system should patients present with any urgent needs or request treatments that were not available at the service. These informed staff if it was appropriate to continue with the appointment booking or refer to NHS 111, urgent care, or accident and emergency. These provided staff with a standard operating procedure to follow. For example, for patients presenting with suicidal thoughts or feelings, those requiring antidepressants, any issues with pregnancy, suspected meningitis, and sepsis were referred on the NHS 111 service or told to dial 999.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing by the doctors. The service had an on-call senior doctor that could be consulted should the doctors require support or advice.
- Care and treatment were delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. For example, the service offered longer appointments if needed.
- There was a system in place to identify frequent callers and patients with particular needs. In the ten patient records we reviewed, we saw no evidence of discrimination when making care and treatment decisions.
- When staff were not able to make a direct appointment on behalf of the patient clear referral processes were in place. These were agreed with senior staff and clear explanation was given to the patient or person calling on their behalf.

Monitoring care and treatment commissioners' requirements

- The commissioner's main requirement for the services was the number of hours the services were available each week, and this was always met by the provider.
- In addition, the provider reported on three services to the Integrated Care Board and informed them of the number of complaints and incidents and the take up of the services. For example: -
- The enhanced access service in March 2023 consisted of 408 hours, out of these hours 975 appointments were offered of which151 patients did not attend their appointments.
- The extended access hub from January to March 2023 offered 8,417 appointments of these 195 patients did not attend their appointments. The number of face-to-face appointments was 4,273.
- The spirometry service offered a one-hour appointment, and in June staff reported they had an average of 70 new referrals each week, The waiting time for an appointment was four to six weeks, which was in line with the service level agreement with the commissioner.

Good

Are services effective?

- During the inspection staff told us the new Chief Executive was carrying out an ongoing review of governance at the service and the team were recognising the gaps and were open to learning new ways of working.

Effective staffing

- Non-clinical staff had completed their mandatory training in basic and paediatric life support, information governance, infection prevention and control, safeguarding adults and children level two, fire safety, chaperoning, and equality and diversity We were told by staff they had an annual appraisal.
- In addition, all handler's calls were listened to and audited every six months, and any issues were discussed with the member of staff by the supervisors. The call handlers also explained that the supervisors would offer support if a difficult call arose.
- The provider had evidence that demonstrated the GP's registration with the General Medical Council and their mandatory training of child and adult safeguarding level 3, basic life support, infection prevention and control, and information governance.
- The clinical director carried out two annual audits of the GPs clinical consultations using the recommended Royal College of Physicians tool. They explained this used to be three cases every six months and more frequently during induction, however due to the increase in the number of staff this had been reduced to two cases annually. The clinical director told us this was insufficient and explained they planned to share out the clinical consultation audits with a clinical lead so that they could increase the number and how often they were carried out.
- In October 2022 the provider had extended their services to offer an enhanced access and spirometry service this provided appointments with advanced nurse practitioners, physicians associates and practice nurses. The provider had evidence the staff had completed adult and children's safeguarding, infection prevention and control and basic life support training and spirometry training.
- To be assured of the clinical staff's competency following the commencement of these services in October 2022 they had carried out two clinical audits of the clinician patient consultations records and ensured that clinical support was always available during their work. At the time of the inspection, there were plans in place to ensure the number of consultations was increased.
- At the time of the inspection the service had designed a system to ensure clinical staff worked within their clinical competencies,however, this was awaiting sign off by the board and had not been implemented.
- The provider had an induction programme for all newly appointed staff.
- We were provided with an example to demonstrate that there was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

- We saw records that showed that all appropriate staff, including those in different teams, services, and organisations, were involved in assessing, planning and delivering care and treatment.
- As staff had access to and recorded their notes in the patients' medical records. Patients received coordinated and person-centred care
- The service ensured that care was delivered in a coordinated way and considered the needs of different patients, including those who may be vulnerable because of their circumstances.
- There were clear and effective arrangements for booking appointments, and transfers to other services.
- Staff were empowered to make direct referrals and/or appointments for patients with other services.

Helping patients to live healthier lives.

- The patient records system enabled the staff to identify patients who may need extra support.
- Where appropriate, staff gave people advice about other services. Systems were available to facilitate this.
- Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs.

Good

Are services effective?

Consent to care and treatment

- The service obtained consent to care and treatment in line with legislation and guidance.
- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians 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 caring.

Kindness, respect and compassion

- 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. Call handlers gave people who phoned into the service clear information.
- The services patient survey information from 1 January to 31 March 2023 found patients stated that 100% found the receptions staff very helpful of helpful.

Involvement in decisions about care and treatment

- Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given): The patient survey information from 1 January to 31 March 2023 found 93% of patients rated the clinician's explanation and treatment as outstanding.
- Interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.
- For patients with learning disabilities or complex social needs family, carers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids.

Privacy and dignity

- Staff always respected confidentiality.
- 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 responsive to people's needs?

We rated the service as good for providing responsive services.

Responding to and meeting people's needs

- The provider was commissioned by the local Integrated Care System to provide support to the GP practices by providing three types of services at Petersfield surgery. These were: -
- The same day extended access service, where same day GP appointments were offered to any patient registered with a Havering GP who called the service.
- The enhanced access service which offered a multidisciplinary team appointments, which enabled patients to access a broader set of services such as vaccinations or monitoring of long-term conditions.
- The spirometry service which offered a spirometry service.
- The service had a system in place that alerted staff to any specific safety or clinical needs of a person using the service.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when people found it hard to access the service.
- The service was responsive to the needs of people in vulnerable circumstances.

Timely access to the service

- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- The same day extended access service offered GP appointments to any patients who called the service on the same day of their call. These were available from Monday to Friday from 6pm to 10 pm Monday to Friday and from 9am to 5pm on a Saturday and Sunday. Patients could book through the call centre, which was open to book appointments on a Monday to Friday 12midday to 9pm and on a Saturday and Sunday from 9am to 5pm. Patients who called the 111 service or attended urgent care could also be offered an appointment.
- The service did not see walk-in patients and a 'Walk-in' policy was in place which outlined what approach should be taken when patients arrived without having first made an appointment, for example patients were told to call NHS 111 or referred onwards if they needed urgent care. All staff were aware of the policy and understood their role with regards to it, including ensuring that patient safety was a priority.
- The provider met the commissioner's performance indicators by submitting a monthly report, ensuring the opening hours of the service and the 111 service and urgent care had access to appointments at the service.
- Unverified performance information submitted by the provider demonstrated, from 1 January to the 31 March 2023, the service had offered approximately 8,700 appointments, of which 4,468 were face-to-face. The service reported which GP services patients had attended from and the number of appointments which had been book through the 111 service and urgent care.
- The enhanced access service appointments were available for GP practices to book their registered patients into, and patients could also book themselves online. These were available from 6.30pm and 10pm Mondays to Fridays and between 9am and 5pm on Saturdays. They delivered general practice services, that included appointments for planned care such as vaccinations, health checks and long-term condition reviews.
- Patients were referred to the spirometry services by their NHS GP. The service was available 6pm to 10pm Monday to Friday and 12pm to 5pm Saturday. The average appointment length was one hour. The present waiting time for the service was between four to six weeks and the service received an average of 70 new referrals each week.

Listening and learning from concerns and complaints

- Information about how to make a complaint or raise concerns was available from the receptionist at the Petersfield surgery.

Good

Are services responsive to people's needs?

- The complaint policy was last reviewed in May 2023 and described the procedure to manage a complaint. We reviewed two complaints and found the investigation and response was carried out by the clinician that the complaint was against. We discussed this with the new Chief Executive Officer who agreed that this would not provide the complainant with a independent investigation of their complaint.
- Issues were investigated and staff feedback to other parts of the patient pathway where relevant.
- The service learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care. We were provided with an example of a complaint where a patient had a missed rare diagnosis, and the findings of the complaint were shared with other clinicians.

Requires Improvement

Are services well-led?

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

- At this inspection we identified some of the gaps in recruitment, training, clinical scope of practice and clinical supervision, which the Chief Executive Officer and staff had identified and were working towards improving but these were either not implemented or embedded at the time of the inspection.
- At the time of the inspection clinical audits had not been carried out regarding staff prescribing and referral decisions to ensure clinical staffs competency.

Leadership capacity and capability

- The Chief Executive Officer had recently been recruited and was reviewing all of the governance procedure with staff.
- Leaders had the experience, capacity, and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Staff told us leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive.
- Senior management was accessible throughout the operational period, with an effective on-call system that staff were able to use.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

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.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The provider planned the service to meet the needs of the local population.
- The provider ensured that staff who worked away from the main base felt engaged in the delivery of the provider's vision and values.

Culture

- Staff told us they 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 we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year.
- Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development.
- There were positive relationships between staff and teams.

Governance arrangements

Requires Improvement

Are services well-led?

- At this inspection we identified some of the gaps in recruitment, training, clinical scope of practice and clinical supervision, which the Chief Executive Officer and staff had identified and were working towards improving.
- The new Chief Executive Officer explained they were carrying out a review of the governance of the service and working towards structures, processes, and systems to support good governance and management.
- The leadership team explained that they meet weekly and report to the board monthly.
- The Chief Executive had developed a quality assurance and management policy which was due to be approved by the board in August 2023. This aimed to put in place a system of checks and monitoring to ensure safe care and treatment. Part of the policy stated the service would establish a quality committee, with terms of reference.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

Managing risks, issues and performance

- At the time of the inspection the processes to manage current and future performance of the clinical staff had not been implemented and clinical audits had not been carried out regarding staff prescribing and referral decisions.
- There were some effective processes in place to identify, understand, monitor, and address current and future risks including risks to patient safety.
- Leaders had oversight of MHRA alerts, incidents, and complaints. Leaders also had a good understanding of service performance against the national and local key performance indicators.
- Performance was regularly discussed at senior management and board level. Performance was shared with staff and the local ICB as part of contract monitoring arrangements.
- The providers had plans in place and had trained staff for major incidents.

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 service used information technology systems to monitor and improve the quality of care.
- 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

- Patient feedback questionnaires and text surveys were available for patients to complete following an appointment. The service collated the feedback and reviewed it every 3 months.
- Staff had access to various meetings. For example, there was a weekly team meeting for managers and non-clinical staff. The leadership team met weekly to review performance, and the service had introduced a nurse peer meeting. The Chief Executive Officer explained they were developing a new pattern of working and meetings which needed to be embedded.
- The service was transparent, collaborative, and open with stakeholders about performance.
- The service had previously had a newsletter to inform the doctors of changes to the service which they hoped to reinstate.

Continuous improvement and innovation

- Staff described the service had a focus on continuous learning and improvement at all levels within the service.

Requires Improvement

Are services well-led?

- Staff knew about improvement methods and had the skills to use them.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Family planning services Diagnostic and screening procedures	Regulation 17 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983 The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • At this inspection we identified some of the gaps in recruitment, training, clinical scope of practice and clinical supervision, which the Chief Executive Officer and staff had identified and were working towards improving but these were either not implemented or embedded at the time of the inspection. • At the time of the inspection the service had not embedded quality improvement activities covering prescribing and referral decisions to ensure the provision of effective care and treatment