Royal Arsenal Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice was previously inspected as part of the new comprehensive inspection programme. We carried out an announced comprehensive inspection at Royal Arsenal Medical Centre on 26 July 2016. The overall rating for the practice was requires improvement. The rating for the safe, effective and well-led key questions was requires improvement and for the caring and responsive key questions the rating was good. The full comprehensive report, published on 29 September 2016, can be found by selecting the 'all reports' link for Royal Arsenal Medical Centre on the CQC website at www.cqc.org.uk.

This report details our findings at the announced focused inspection carried out on 22 February 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 26 July 2016. This report covers our findings in relation to those requirements and any improvements made since our last inspection.

Overall the practice is now rated as good. Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and staff understood their responsibilities to raise concerns and report incidents and near misses. A system was in place to ensure that records of investigations and correspondence were maintained and there was evidence of learning communicated to staff through weekly minuted meetings.
- Risks to patients were assessed and well managed. There was a failsafe process in place to ensure that results for all specimens taken for cervical cytology had been received and there was a system in place to monitor the rate of inadequate specimens sent for analysis.
- We saw evidence that recent comprehensive risk assessments had been undertaken for Health and Safety, Legionella, Fire Safety and Disability Discrimination Act compliance.
- The recruitment procedure had been revised to include the retention of evidence that registration status was checked for all professional staff prior to commencing employment.

Summary of findings

- An annual staff review checklist had been implemented by the practice which included a monitoring process to alert the manager when registration revalidation and annual appraisals were due for all staff.
- A programme of annual staff appraisal and development reviews had been implemented by the practice.
- All recommended emergency medicines were available, in date and stored in a safe accessible location.
- A comprehensive Business Continuity and Recovery Plan, confirming the practice arrangements for responding to emergencies and major disruptions to services was now in place.
- As the practice had been unsuccessful in recruiting members to the Patient Participation Group they were proactively recruiting patients to a patient reference group instead. Communication to members of the group was carried out by email.
- All current Patient Group Directions (PGDs) were signed by both the authoriser and relevant practitioners.
- The content of Patient Specific Directions (PSDs) complied with the required criteria.
- The provider had implemented a process to record batch numbers of blank electronic prescriptions placed in individual printers.
- The provider had implemented a new procedure to ensure blood test monitoring was carried out prior to the repeat prescribing of high risk medicines.
- The provider continued to monitor staffing arrangements and patient satisfaction rates in order to improve continuity of care and the availability of appointments. A new salaried GP, locum GP and practice nurse had recently been recruited.
- Data from the 2015/16 Quality and Outcomes Framework (QOF) showed patient outcomes were below the local and national average in several areas.
- QOF exception reporting rates were comparable with local and national averages.

There were areas of practice where the provider must continue to make improvements:

- The provider must continue to develop and implement quality improvement processes and monitor performance against the Quality and Outcomes Framework and clinical audit in order to improve clinical outcomes for patients.

There were areas of practice where the provider should continue to make improvements:

- The provider should continue to consider proactive strategies to encourage patients to join the patient participation group (PPG).

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- Staff understood their responsibilities to raise concerns and report incidents and near misses. The practice had improved their procedure for incident reporting to ensure records were kept of all investigations and correspondence.
- To ensure that improvements and changes identified as a result of investigations were communicated to all staff this was now a standing agenda item on weekly staff meetings and minutes were recorded and circulated to all staff.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. Contact numbers for referring patients to the local safeguarding team were now readily accessible to staff.
- Risks to patients who used services were assessed and the systems and processes to address these risks were implemented. The Practice Nurse had implemented a failsafe process to ensure that results for all specimens taken for cervical cytology had been received and there was a system in place to monitor the rate of inadequate specimens sent for analysis.
- A comprehensive Health and Safety, Legionella and Fire Safety Risk Assessment had recently been undertaken.
- The recruitment process included the appropriate professional registration check and an annual staff review checklist had been implemented by the practice which included a monitoring process to alert the manager when registration revalidation and annual appraisals were due for all staff.
- A programme of annual staff appraisal and development reviews had been implemented by the practice.

Are services effective?

Requires improvement

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

- Data from the 2015/16 Quality and Outcomes Framework (QOF) showed patient outcomes were below the local and national average in several areas. The provider had continued to work towards identifying and developing strategies to improve performance.
- The exception reporting rates for 2015/16 were comparable to local and national averages.

Summary of findings

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- A programme of annual staff appraisal and development reviews had been implemented by the practice.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs and multidisciplinary working was taking place. A record was kept of the issues discussed at these meetings.

Are services well-led?

Good

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

- The practice had a number of policies and procedures to govern activity and there was a system in place to ensure that these were easily accessible to all staff.
- The practice had systems in place for the processing of notifiable safety incidents and there was evidence that they adhered to this process. The practice had systems in place to formally share learning with staff and to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients which it acted on.
- The patient participation group was not active. However as the practice had been unsuccessful in recruiting members to the Patient Participation Group they were proactively recruiting patients to a patient reference group where communication was carried out by email.
- Minutes of meetings were recorded to ensure learning and changes required were shared with all relevant staff.
- A programme of annual staff appraisal and development reviews had been implemented by the practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The provider had resolved the concerns identified in the key questions of safe, effective and well-led at our previous inspection on 26 July 2016. This applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

People with long term conditions

Good

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

The provider had resolved the concerns identified in the key questions of safe, effective and well-led at our previous inspection on 26 July 2016. This applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Families, children and young people

Good

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

The provider had resolved the concerns identified in the key questions of safe, effective and well-led at our previous inspection on 26 July 2016. This applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Working age people (including those recently retired and students)

Good

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

The provider had resolved the concerns identified in the key questions of safe, effective and well-led at our previous inspection on 26 July 2016. This applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

People whose circumstances may make them vulnerable

Good

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

Summary of findings

The provider had resolved the concerns identified in the key questions of safe, effective and well-led at our previous inspection on 26 July 2016. This applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.	
People experiencing poor mental health (including people with dementia) The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The provider had resolved the concerns identified in the key questions of safe, effective and well-led at our previous inspection on 26 July 2016. This applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.	Good

Summary of findings

Areas for improvement

Action the service MUST take to improve

The provider must continue to develop and implement quality improvement processes and monitor performance against the Quality and Outcomes Framework and clinical audit in order to improve clinical outcomes for patients.

Action the service SHOULD take to improve

The provider should continue to consider proactive strategies to encourage patients to join the patient participation group (PPG).

Royal Arsenal Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a compliance inspector.

Background to Royal Arsenal Medical Centre

Royal Arsenal Medical Centre is situated in the Royal Borough of Greenwich in an area recently developed to include a large amount of residential accommodation.

Services are provided from one location at 21 Arsenal Way London SE18 6TE, which is a large purpose-built medical centre, part of a new residential and leisure complex.

Greenwich Clinical Commissioning Group (CCG) is responsible for commissioning health services for the locality.

The practice relocated to the current purpose-built leased premises in 2012, from smaller premises very close to the current site. The practice accommodation comprises eleven consulting/treatment rooms; four waiting areas; a medical record storage room, staff room and administrative offices. Part of the premises is sub-let to other services for which practice staff provide reception services. These services include Lifeline Basis (Alcohol and Drugs advisory/counselling service), Physioworld (ATOS screening), Greenwich Time to Talk counselling services, Greenwich Mind counselling services, Anti-coagulation clinic, community dermatology service, Guys & St Thomas CHANT Team and AAA Screening, Lewisham & Greenwich Trust Rehabilitation service, an independent Physiotherapy service and an independent Podiatry service.

The practice also hosts a twice-weekly phlebotomy clinic and a weekly community midwifery service. The practice is adjacent to a pharmacy.

The practice has 9047 registered patients (an increase of approximately 3,000 patients over the past three years). Compared to the national average the practice has a much higher number of patients in the 25 to 45 year age group and a lower than average number of patients in the 60 plus age group.

The practice is based in an area with a deprivation score of 5 out of 10 (1 being the most deprived and 10 the least deprived).

The practice has agreed to provide a number of local and national enhanced services (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

Services are delivered under a Personal Medical Services (PMS) contract. The practice is registered with the CQC to provide the regulated activities of family planning; treatment of disease, disorder and injury, surgical procedures and diagnostic and screening procedures. The practice is in the process of registering for the Regulated Activity of maternity and midwifery.

The practice is currently registered with the CQC as a Partnership. However, the partnership status of the practice is currently under review as there is only one active partner in the practice at present. The current partner is therefore in negotiations with NHS England and CQC regarding the re-registration of the practice.

Medical services are provided by six GPs and a Nurse Practitioner (NP) providing a total of 40 sessions a week.

The lead GP provides 8 sessions per week: one female salaried GP (8 sessions): four (male and female) long term locum GPs (14 sessions); one male short term locum GP (2

sessions) and one Nurse Practitioner (NP) (8 sessions). Patients are given the choice of a GP or NP when booking their appointments. Only GP appointments are available to book online.

Clinical services are provided by four Practice Nurses (2 wte) and one Health Care Assistant (0.5 wte).

Administrative services are provided by a Practice Manager (1.0 wte); eight administration staff (6 wte) and five reception staff (4 wte).

The practice reception and telephone lines are open between 8am and 6.30pm Monday to Friday. Reception is also open for extended hours between 7am and 8am on Tuesday, between 7.30am and 8am on Wednesday and between 9.30am and 12.30pm on Saturday.

In addition to pre-bookable appointments, urgent appointments are available the same day for people who need them.

Urgent and routine appointments are available with the GP or Nurse Practitioner from 8am to midday and 2pm to 5.40pm on Monday; from 7am to midday and 1pm to 5.40pm on Tuesday; from 7.30am to midday and 1.30pm to 5.40pm on Wednesday; from 8.30am to 5.40pm on Thursday; from 8.10am to midday and 3pm to 5.40pm on Friday and from 9.30am to 12.30pm on Saturday.

Appointments with the Practice Nurse are available from 8.30am to 12.30pm and from 2.00pm to 5.00pm Monday to Wednesday, from 8.30am to 12.30pm Thursday, from 8am to 12.30pm and from 2pm to 6.30pm Friday and from 9.30am to 12.30pm on Saturday.

Appointments with the Health Care Assistant are available from 3pm to 6.30pm on Monday, Wednesday and Friday and from 9.30am to 1pm on Saturday.

A practice leaflet is available and the practice website includes details of services provided by the surgery.

Why we carried out this inspection

This practice was previously inspected as part of the new comprehensive inspection programme. We carried out an announced comprehensive inspection on 26 July 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was undertaken to check that the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

The overall rating for the practice following the inspection on 26 July 2016 was requires improvement. The rating for the safe, effective and well-led key questions was requires improvement and for the caring and responsive key questions the rating was Good. The full comprehensive report, published on 29 September 2016, can be found by selecting the 'all reports' link for Royal Arsenal Medical Centre on the CQC website at www.cqc.org.uk.

We undertook an announced focused inspection of Royal Arsenal Medical Centre on 22 February 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

We carried out an announced focused inspection which involved reviewing evidence that the practice were now meeting the relevant requirements.

During our visit we spoke with the GP partner, Practice Manager and Practice Nurse and reviewed practice documentation, such as:

- A selection of policies and procedures
- Risk assessments
- Minutes of meetings
- Data from the Quality and Outcomes Framework 2015/16
- Patient Group Directions (PGDs)
- Patient Specific Directions (PSDs)
- Staff appraisal plans and a selection of staff appraisals.
- Reviewed emergency medicines

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

Good

Are services safe?

Our findings

At our previous inspection, carried out on 26 July 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of incident reporting, safety systems and processes, monitoring risks to patients and arrangements for dealing with emergencies and major incidents were not adequate.

We issued a requirement notice in respect of these issues and found significant improvements had been made when we undertook this announced follow-up focused inspection on 22 February 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

At the previous inspection we found that:

- There was an informal and unstructured system in place for reporting and recording significant events.
- Records were not kept of all reported incidents including correspondence and actions undertaken.
- Staff were informally told of changes to be made as a result of investigations and minutes of meetings where these were discussed with staff were not kept.

At this inspection we saw evidence that improvements had been made in these areas:

- There was a structured system in place for reporting and recording significant events.
- Records were kept of reported incidents including correspondence and actions undertaken.
- Staff were informed of changes to be made as a result of investigations at weekly staff meetings. Incident reporting was included as a standing agenda item for meetings and minutes of meetings where recorded and made available to all staff.

Overview of safety systems and process

At the previous inspection we found that:

- Safeguarding policies were accessible to all staff and contained guidance for staff if they had concerns about a patient's welfare but did not contain details of who to contact if referrals or further guidance were required.
- There was no failsafe process in place to ensure that results for all specimens taken for cervical cytology had been received and there was no system in place to monitor the rate of inadequate specimens sent for analysis.
- Procedures were in place for handling repeat prescriptions but these did not include failsafe processes to ensure patients receiving high risk medicines were reviewed as appropriate.
- Supplies of blank prescription sheets for printers were stored in a locked cupboard but records of batch numbers of prescriptions put in individual printers were not maintained.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Current PGDs had not all been signed by the relevant authorising personnel. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.)
- The Health Care Assistant had been trained to administer vaccines and medicines against patient specific directions (PSDs). However, PSDs used by the practice did not always state the names of individual patients. (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).
- Personnel files did not include confirmation that registration checks with the appropriate professional body had been carried out prior to commencing employment and there was no system in place to check that professional revalidation was kept up to date for clinical staff.

At this inspection we saw evidence that improvements had been made in these areas:

- Details of who to contact if staff needed to make a safeguarding referral or required further guidance was readily available.
- There was a failsafe process in place to ensure that results for all specimens taken for cervical cytology had been received and there was a system in place to monitor the rate of inadequate specimens sent for analysis.

Good

Are services safe?

- Procedures for handling repeat prescriptions included processes to ensure patients receiving high risk medicines were monitored and reviewed as appropriate.
- Supplies of blank prescription sheets for printers were stored in a locked cupboard and records of batch numbers of prescriptions put in individual printers were maintained.
- Current PGDs were signed by the relevant authorising personnel and nursing staff.
- PSDs used by the practice included all appropriate information.
- Personnel files included confirmation that registration checks with the appropriate professional body had been carried out and there was a system in place to check that professional revalidation was kept up to date for clinical staff. An annual staff review checklist had been implemented by the practice which included a monitoring process to alert the manager when registration revalidation and annual appraisals were due for all staff.

Monitoring risks to patients

At the previous inspection we found that:

- A health and safety assessment and Legionella risk assessment had not been carried out since moving to the current premises in 2012. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

At this inspection we saw evidence that improvements had been made in these areas:

- We saw evidence that recent comprehensive risk assessments had been undertaken for Health and Safety, Legionella, Fire Safety and Disability Discrimination Act compliance.

Arrangements to deal with emergencies and major incidents

At the previous inspection we found that:

- Some recommended emergency medicines were not available.
- The practice did not have a Business Continuity Plan in place to confirm practice arrangements for responding to emergencies and major disruptions to the service such as power failure or building damage.

At this inspection we saw evidence that improvements had been made in these areas:

- All recommended emergency medicines were available, in date and stored in a safe accessible location.
- A comprehensive Business Continuity and Recovery Plan was in place which detailed the practice arrangements for responding to emergencies and major disruptions to services.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection carried out on 26 July 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of patient outcomes and provision of staff induction, updating and appraisal were not adequate.

We issued a requirement notice in respect of these issues and found significant improvements had been made when we undertook this announced follow-up focused inspection on 22 February 2017. However, the practice remains rated as requires improvement for providing effective services as the Quality and Outcomes Framework (QOF) data for 2015/16 showed that the practice performance for several indicators was no longer comparable with local and national averages.

Effective needs assessment

At the previous inspection we found that:

- The practice did not have systems in place to ensure all clinical staff were kept up to date with current evidence based clinical guidelines.

At this inspection we saw evidence that improvements had been made in these areas:

- Relevant newly released guidelines were now discussed at weekly clinical meetings. Notes were recorded of the issues and actions discussed at the meetings and circulated to all clinical staff.

Management, monitoring and improving outcomes for people

At the previous inspection we found that:

- The 2014/15 overall exception reporting rate for all clinical domains was 17% which was higher than the Clinical Commissioning Group (CCG) average of 7% and national average of 9%.

At this inspection we saw evidence that improvements had been made in these areas:

- The 2015/16 overall exception reporting rate for all clinical domains was 8% which was comparable with the Clinical Commissioning Group (CCG) average of 7% and national average of 10%.

At the previous inspection carried out on 26 July 2016 the most recently published Quality and Outcomes Framework (QOF) data used was for 2014/15. This showed that the practice performance for all indicators was comparable to the CCG and national average. However, at this inspection the most recently published data available was for 2015/16. This data showed that the practice performance rate for several QOF indicators was below the CCG and national average:

- The performance rate for indicators related to diabetes was 61% compared to the CCG average of 78% and national average of 90%.
- The performance rate for indicators related to asthma was 77% compared to the CCG average of 93% and national average of 97%.
- The performance rate for indicators related to COPD (chronic obstructive pulmonary disease) was 58% compared to the CCG average of 88% and national average of 96%.
- The performance rate for indicators related to hypertension was 64% compared to the CCG average of 91% and national average of 97%.
- The performance rate for indicators related to peripheral arterial disease was 71% compared to the CCG average of 96% and national average of 97%.

Performance for all other QOF indicators was comparable to the CCG and national average.

The exception reporting rate for these indicators was comparable to the CCG and national average.

The provider was aware of the need to make improvements to patient outcomes as identified in their 2015/16 QOF performance rates and had therefore developed a strategy to address this. The projected year end QOF figures for 2016/17 forecast some improvement in the performance rates for indicators related to asthma, COPD and peripheral arterial disease.

Effective staffing

At the previous inspection we found that:

- The practice did not have a formal induction programme for newly appointed staff to cover such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Staff had regular informal discussions with the practice manager but had not received a formal annual appraisal.

At this inspection we saw evidence that improvements had been made in these areas:

- The practice had developed a formal induction programme for newly appointed staff which covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- A structured programme of annual staff appraisal and development reviews had been implemented by the practice. The provider had implemented a monthly programme for appraisals to ensure all staff received a comprehensive annual appraisal. Clinical staff were to be appraised by the lead GP and administrative staff by the Practice Manager. We saw evidence that the practice had commenced the programme for the initial appraisals and aimed to complete all appraisals in the next few months.

Are services well-led?

Good

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

Our findings

At our previous inspection carried out on 26 July 2016, we rated the practice as requires improvement for being well-led as the arrangements in respect of the overarching governance structure were not adequate.

We issued a requirement notice in respect of these issues and found significant improvements had been made when we undertook this announced follow-up focused inspection on 22 February 2017. The practice is now rated as good for being well-led.

Vision and strategy

At the previous inspection we found that:

- Monitoring procedures to ensure the practice continued to work in line with the practice vision to provide quality care were informal and unstructured.

At this inspection we saw evidence that improvements had been made in these areas:

- The practice had formalised and structured their governance processes and procedures.

Governance arrangements

At the previous inspection we found that:

- The practice had a governance procedure in place which supported the delivery of good quality care but this was informal and unstructured.
- Clinical audit had been carried out but there was no planned audit programme to monitor quality and to identify required improvements.
- There were arrangements for identifying and managing risks, issues and implementing mitigating actions but these were often informal with few written records maintained.

At this inspection we saw evidence that improvements had been made in these areas:

- The practice had formalised and structured their governance processes and procedures.
- Records were kept of reports, investigations and correspondence related to incidents and complaints and minutes of staff meetings were recorded where learning was shared with all staff.

Leadership and culture

At the previous inspection we found that:

- The provider told us they prioritised safe, high quality and compassionate care. However, due to the absence of formal processes and procedures they were unable to demonstrate that services were well run or that risks to patients were assessed and well managed.
- There were no formal procedures to identify necessary changes and improvements to the service or for staff to be kept updated.
- The practice informed us that they took action when things went wrong with care and treatment. However, the practice was unable to provide evidence of this as they did not keep written records of all investigations, verbal interactions and written correspondence.
- Staff told us the practice held regular team meetings. However, these were informal and minutes of meetings were not recorded.

At this inspection we saw evidence that improvements had been made in these areas:

- The practice had formalised and structured their governance processes and procedures which prioritised safe, high quality and compassionate care.
- Records were kept of reports, investigations and correspondence related to incidents and complaints and staff were kept updated at regular staff meetings.
- The practice now had an agenda and minutes for all staff meetings which included standing agenda items for the sharing of learning from incidents and complaints.

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

At the previous inspection we found that:

- The patient participation group (PPG) had been discontinued due to lack of members.
- The practice had gathered feedback from staff through informal discussion and staff meetings which took place every few weeks. However, minutes of these meetings were not recorded and could not therefore be shared with absent staff members.

At this inspection we saw evidence that improvements had been made in these areas:

Are services well-led?

Good

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

- The practice continued to find it difficult to recruit members to the PPG so had actively recruited members to a patient reference group. Communication with this group of patients was by email.
- Minutes of all staff meetings were recorded and made available to all staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider must improve clinical performance and patient outcomes by implementing an effective clinical quality improvement programme and monitoring performance against clinical audit results and the Quality and Outcomes Framework.