Good

Navigo Health and Social Care CIC

Community-based mental health services for adults of working age

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-1206855621	NAViGO House	Weelsby View Medical Centre	DN32 9SW
1-1206855621	NAViGO House	Scartho Medical Centre	DN33 3JF

This report describes our judgement of the quality of care provided within this core service by NAViGO Community Interest Company. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by NAViGO Community Interest Company and these are brought together to inform our overall judgement of NAViGO Community Interest Company.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated NAViGO Community Interest Company as good because:'

- The premises were clean and tidy with separate spacious waiting areas. The teams worked to a lone working practice protocol. Interview rooms were alarmed or systems were in place to keep staff safe. Staffing levels were safe to meet the needs of patients.
- Staff were aware of safeguarding requirements and showed they understood the referral process into the local authority. Caseloads were managed and re-assessed regularly and were discussed in supervision.
- There was an effective incident reporting system in place and there was learning from serious incidents. All staff knew how to report an incident.
- Risk assessments were recorded and updated regularly. Comprehensive assessments were completed in a timely manner. Care records showed personalised care, which was recovery oriented. Physical healthcare needs were considered during assessment and throughout treatment. There was consideration of mental capacity assessment throughout treatment and this was documented. Outcome measures were used to evaluate the effectiveness of care and treatment. Medicines were managed safely and there was learning from medication incidents.
- Staff were respectful and caring when they spoke with people. People said they felt involved in their care planning and treatment and this was documented in the care record.
- There were no waiting times from referral to triage due to the single point of access. Referral to assessment waiting times were 11.5 days against a10 day target and referral to treatment or second offered contact date was 22 days. The east team did not have a waiting list and the west team were monitoring those on the waiting list.
- Managers monitored performance and addressed any issues. Staff received appraisals and regular supervision. All staff said they could raise issues with their manager if required and action would be taken. Staff knew the senior managers and were aware of the trust's vision and values. The chief executive attended regular staff meetings and some staff were members of the board. They said they felt supported by the board members and senior management. Team morale was good and staff worked well together.

However:

- There were continuing staffing issues at the east team and the team were under pressure to manage the workload. The staffing issues had continued for a considerable amount of time. This meant that caseload sizes were increasing and the west team had started to give assistance.
- Mandatory training compliance was below target for safeguarding adults, safeguarding children, and information governance.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

We rated safe as requires improvement because:

Mandatory training completion rates were below target in some areas. There were continuing staffing issues at the east team, which could affect the service if not resolved as staff become overworked

However

- Risk assessments were completed and updated as necessary for each patient.
- Lone workers policies were followed and premises were safe and clean.
- Staffing levels were safe for the service and there was access to a consultant psychiatrist.
- Medicine management was safe with good governance systems in place.
- Incidents were recorded and learnt from and staff understood their responsibilities in relation to safeguarding.

Are services effective?

Good

We rated effective as good because:

- Care plans were up to date, regularly reviewed and recovery focused.
- Patients had access to psychological therapies, group work and activities.
- Physical health was assessed and monitored throughout treatment.
- Staff had regular supervision and there was effective team working
- The service took part in regular clinical audits to improve service delivery.

Are services caring?

Good

We rated caring as good because:

- We found that staff were respectful and caring towards patients, who felt involved in their care and treatment.
- Families and carers were involved in treatment and given support for themselves.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Summary of findings

- Services were easy to access and appointments for assessment were flexible. Patients could access help from the crisis team out of hours if needed.
- Multi-disciplinary meetings were taking place and a pilot to look at discharge had been developed.
- Premises were accessible and patients knew how they could make a complaint

Are services well-led?

Good

We rated well-led as good because:

- Staff understood and shared the organisations visions and values.
- Staff were supported by the chief executive and other senior managers who were open and transparent
- There were good governance systems in place to monitor performance and clinical care.

Summary of findings

Information about the service

NAViGO provided community mental health services to adults of working age living in North East Lincolnshire and surrounding areas who were experiencing moderate to severe mental health problems.

The service operated across two teams, these were the east and west teams, and were based in health centres in Grimsby. The teams consisted of community psychiatric nurses, consultant psychiatrists, occupational therapists, psychologists, social workers, and support staff.

The service provided

- assessment and initial treatment advice
- care plans developed with patients
- pharmacological interventions and medication management
- psychological therapies, mainly cognitive behavioural therapy and brief psychological interventions aimed at the specific disorder
- support for carers and families
- regular care plan reviews
- information and support with employment and activities of daily living
- advice on health and wellbeing
- crisis planning and relapse prevention.

Tailor made packages of care were developed for patients with severe and/or enduring mental health and social care needs. Care coordinators provided support through a care plan and recovery process.A single point of access team provided initial assessment of referrals.

The community mental health teams were inspected on 30 January 2014 and found to be meeting all standards.

Our inspection team

Our Inspection Team was led by was Patti Boden, Inspection Manager, Hospitals Directorate North East, Care Quality Commission.

The team inspecting the Community based mental health services for adults of working age was consisted of: one CQC Inspector, one occupational therapist, one social worker and one nurse.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and NAViGO Community Interest Company :

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information, and sought feedback from patients at three focus groups.

Summary of findings

During the inspection visit, the inspection team:

- visited the east and west community mental health teams and looked at the quality of the environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- spoke with the managers from both of the community mental health teams
- spoke with eleven other staff members; including doctors, nurses, social workers and support workers
- attended and observed three home visits and one multi-disciplinary meetings.
- collected feedback from patients using comment cards.
- looked at eight treatment records of patients

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

The four patients we spoke to told us that they could always get an appointment and would usually be seen within days. They could also access verbal advice over the phone between appointments. People knew who to contact if they did not feel well.

Staff were polite and involved people in their care and treatment. Copies of care plans were made available if wanted. They were able to give feedback on the service. Information was given to people who use services and those who supported them on what treatment was available.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff are up to date with mandatory training.

Action the provider SHOULD take to improve

- The provider should ensure that staffing issues within the east team are resolved to ensure that a safe service continues to be provided to patients.

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Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Weelsby View Medical Centre	NAViGO House
Scartho Medical Centre	NAViGO House

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about NAViGO Community Interest Company.

We found that staff had a good understanding of the Mental Health Act (MHA) and were adhering to the code of practice and the guiding principles. Patients were assumed to have capacity and consent to treatment was obtained. Patients understood their rights and were supported to understand the services available to them. There were good links with the independent mental health advocate for support and advice and patients could access the service. The organisation undertook regular audits of the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff had a good understanding of the Mental Capacity Act (MCA) and had access to support if needed. Staff were able to talk through cases where the MCA had been applied. We saw evidence that staff had used the act appropriately when patient capacity had been impaired. We saw evidence of where best interest's decisions had been made.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

The service premises were clean, tidy, and well maintained. Cleaning records were up to date and infection control policies were being followed. Clinic areas were very clean with good stock rotation. Depot injections were used as necessary and these were stored in either a fridge or a cupboard and temperature checked daily. Medication was checked in and out and relevant documents were completed to monitor this. Interview rooms in the east team were fitted with alarms, which were linked to the reception area. The west team interview rooms were not alarmed but staff always took a mobile phone into appointments and procedures were followed to keep staff safe.

Safe staffing

The service had been restructured from four teams to two teams. The teams were made up of generic care coordinators from various disciplines including nurses, social workers, and occupational therapists. The teams also had support staff and administrative teams. Staff worked normal office hours, which were usually 9.00-17.00 unless previously agreed with management.

The west team were fully staffed and had no vacancies. The team had 16.4 care coordinators made up of nurses, social workers and one occupational therapist. One support worker, one employment worker, and administrators supported the team.

The east team had eight care coordinators, made up of five nurses, two social workers, and one occupational therapist. The team also had one employment worker and one support worker. The east team had ongoing staffing issues due to a number of reasons, which included maternity leave, long-term sickness, suspension, and two recent vacancies due to people finding new employment. Senior managers were attempting to resolve these issues and the team manager had been given authority to recruit two agency workers. The west team were assisting with staffing issues by supporting the new patient screening clinics.

Each team had a full time consultant psychiatrist and full time psychologist. Consultant appointments were always available and appointments could be made within days of referral. Patients could access the crisis team and acute services out of hours if needed either by telephone or by attending the reception. The teams worked closely together to manage patients who had accessed both services.

The organisation had been working to a payment by results model since April 2011. Patients were put into clusters using the mental health-clustering tool. A cluster is a global description of a group of people with similar characteristics The department of health clustering booklet was used as guidance to determine the clusters for the service.

The west team had 507 on the payment by results caseload and the east team had 463. Staff caseloads were usually between 30-40 but were increasing in the east team due to the ongoing staffing issues. Caseload sizes were regularly monitored through staff supervision. Both teams supported each other in terms of covering to ensure patient safety.

Managers in both teams held a small caseload, which was usually made up of the most complex cases.

Mandatory training completion rates were low for both teams for safeguarding adults and information governance. In the west, safeguarding children training was below target. This was being looked at by the service although staff were not yet booked onto courses.

Safeguarding Adults - East 29%, West 47%

Safeguarding Children - East 100%, West 71%

Information Governance - East 57%, West 47%

An introduction to infection prevention and control was included on the induction programme. All staff in the east team had completed the induction and 88% in the west. Two-hour principles of infection training and a one-hour update session were available for all staff that had patient/service user direct contact. These sessions ran throughout the year and 100% of staff in the east team had completed the training with 63% of staff in the west team.

Assessing and managing risk to patients and staff

Patients had risk assessments, which were updated as required and as risks changed. Patients who were new to

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

the service were risk assessed by the single point of access on referral and could be seen at the organisations premises if risks were assessed as high. Risks looked at suicide, substance misuse, self-neglect and vulnerability, violence and safeguarding. Risk management plans were developed for each patient and could be jointly completed with the crisis team if required. In both teams' 96% of patients had a crisis plan in place. Completion of risk assessments was audited during supervision and was a performance indicator for the service. An electronic system was used which had an alert function to notify staff if there were any risks associated with the patient. This was being used in the records we reviewed.

The west team manager monitored the waiting list responding to any deterioration in a person's mental health. The east team did not have a waiting list.

Patients were allocated a care coordinator who worked with them to establish their health and social needs. Patients own GPs usually started them on medication and care coordinators worked closely with GPs for advice and support. The consultant psychiatrist was responsible for prescribing medications to patients who did not receive treatment from their own GP. The consultant worked closely with GPs in primary care.

Staff followed the organisations policy and knew how to report safeguarding and good links existed with the local authority in relation to both adults and children's safeguarding.

The service followed the organisations lone worker policy. Staff in both teams had access to each other's diaries and a buddy system was in place for when patients were seen in the community. White boards were visible in administration rooms, which monitored staff visits. The teams had code words, which could be used to alert colleagues of any issues.

Track record on safety

The west team had four serious incidents in the last 12 months, which related to three patient deaths and one attempted suicide. Senior staff members had investigated all incidents appropriately and learning from these was fed back to teams. Incidents were discussed at the clinical governance meetings as well as in local team meetings. The organisation sent incident learning briefings to staff by email.

We saw evidence of a worker being supplied with a locked bag to carry medications as they were using public transport and working alone in deprived areas. The bag was similar to a lap top bag.

Reporting incidents and learning from when things go wrong

All staff we spoke to had a good understanding of how to identify and report incidents. All incidents were recorded on the datix system. These were sent to managers and to the health and safety link person if necessary by email. Incidents included patient safety, medications issues, and near misses.

Staff were open and transparent and understood the importance of explaining when things had gone wrong. Staff received feedback from incidents during weekly business meetings and through regular emails from the corporate team.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

New patient screening clinics took place daily and patients could access the closest community venue to their home. Referrals came from the single point of access who took all initial contacts and directed them to the most appropriate service within the organisation. New patients were given a telephone triage before being given an appointment for an assessment. Comprehensive assessments were completed on each patient, which covered health and social needs. The west team manager was piloting an integrated assessment approach with patients, which would be rolled out to the east team if successful.

The assessment determined the most appropriate treatment for the patient. If the patient met the criteria for the service, they were allocated a care coordinator. If the patient did not meet the criteria, they would be transferred to more appropriate services to meet their needs, which could include the substance misuse service or Navigo's IAPT Service, Open Minds, which provided care and support for people who are experiencing common mental health problems such as stress, depression, and anxiety. .

Each patient had a care programme approach (CPA) assessment carried out at least annually and the east team had 95% completion with the west team having 93%. A CPA is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs Care plans were updated at least every three months. The eight care plans reviewed were personalised and recovery orientated.

Best practice in treatment and care

Patients had access to psychological therapies and a psychologist ran clinics in both areas. There had been 58 referrals to adult psychology in the last six months and of those referred 38 had accessed. The majority of service users who had not yet accessed psychology had been referred in January 2016 and would be offered assessment appointments throughout February and March 2016.

The organisation offered transcranial magnetic stimulation (TMS). TMS is a painless, non-invasive stimulation of the human brain. The service had referred 15 people in the last six months and nine had accessed the treatment. Those who did not access treatment were not appropriate for TMS.

There was a range of groups available to patients either directly from the organisation or within the community. These included:

- emotional group
- mindfulness
- anxiety group
- friendship group
- walking group
- football group
- referral to smoking, cancer, substance misuse.

There were 54 patients accessing groups to support their care and treatment.

The employment worker supported patients to look at employment issues and worked closely with Tukes. Tukes was the organisations innovative employment and training scheme, established in July 2003 to provide training and employment opportunities to people who were using the services. Patients were also supported with housing and welfare benefits.

Physical healthcare needs were assessed and monitored throughout treatment. Clinics took place regularly to look at health and wellbeing. These included a comprehensive overview of physical health including bloods, an electrocardiogram (a simple test that can be used to check your heart's rhythm and electrical activity), weight and physical observations. Access to weight management support was available.

The consultant psychiatrist audited health checks yearly and encouraged all staff to monitor physical issues in patients. The organisation had won an award for the National Audit for schizophrenia for its monitoring of physical needs.

Outcome measures were in place and were monitored as part of the payment by results contract. These included

- patient related outcome measure
- clinical related outcome measure
- patient related experience measure

The service took part in various audits, which included prescribing audit, chronic physical health, and depression audit, record keeping audit. The organisation had a rolling audit programme and monitored the service on completion rates.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Skilled staff to deliver care

The teams included the full range of disciplines including consultant psychiatrist, senior care coordinators who were nurses, social workers or occupational therapists and generic support workers. A carers worker had been recruited to work across both teams. The role would be focusing on completion of carer's assessments, attending forums, and training around carer's issues. Managers were aware that this was one post and could easily become overworked.

Regular supervision using a supervision audit training record was taking place. The audit covered patient details, risk management, care plan, reviews, and worker allocation. Workload management was assessed during supervision using the review tool, cases of concern were discussed, and individual staff performance was reviewed

Staff were experienced and qualified to provide the required care and treatment. They had completed the corporate induction and specific training was available to staff who needed it, for example dialectical behaviour therapy and behavioural family therapy. A staff member had been supported to change working hours to enable evening sessions to be delivered. Training was organised by the training department who worked closely with local universities (Hull and Lincoln) and also arranged social work and nurse placements.

Multi-disciplinary and inter-agency team work

Multi-disciplinary meetings took place to discuss individual patents and we saw evidence in meeting notes that members of the team and external people working with the patient attended these. Fortnightly access meetings took place to discuss, patients of concern, carer assessments, community clinic schedules, acute services ward admissions and discharges, new referrals and CPA assessments. Business meetings took place monthly, we saw evidence of manager updates, learning from incidents, and general team updates.

There was effective inter-service and joint working with others when needed. For example working with the crisis and home treatment teams when someone needed increased input. There were good links with primary care and both teams worked closely with GPs. There were three GP practices who worked closely with the consultants.

There was an identified lead for dual diagnosis and good links with substance misuse and housing services.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Mental Health awareness training was 100% in the west team but no one in the east team had completed the training. However, staff showed a good understanding of the act and how to apply it. The organisation monitored and audited the use of the act regularly.

Staff were able to contact the approved mental health professional (AMHP) service to co-ordinate assessments under the Mental Health Act.

Advocacy information was available for patients, and staff were aware of how to support patients to access advocacy services. Patients told us they knew about advocacy services and how to access them if needed.

Good practice in applying the Mental Capacity Act

Staff had received training in the use of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards, Mental capacity act basic awareness was 100% for the east team and 94% for the west team. Mental capacity act training was 100% for the east team and 88% for the west team. MCA training was provided through the AMHP either as requested or in response to incidents that had identified a training need.

Staff showed a good understanding of mental capacity and consideration was evident in the care records. We saw evidence of patients who were lacking in capacity and this was documented in their care files. We saw evidence in case files of mental capacity assessments and best interests meetings. Information about local advocacy service was available and we saw that this was used.

Team meetings included discussions around capacity and staff had access to the MCA policy. MCA was discussed in consultant appointments and documented in letters and progress notes. Discussions were taking place with AMHP and independent mental health advocate and these discussions were also documented.

Staff felt the MCA training was of a good standard and examples were given where capacity assessments had led to best interests meetings. Staff had a link person they could contact for advice and support on MCA issues.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Staff were involving patients in discussions about their care and treatment. Patients spoke positively about the service and felt they were provided with a good level of emotional and practical support.

The involvement of people in the care that they receive

We observed patients being involved in their care and treatment. Discussions took place around care plan changes and information was given about any referrals being made to other services. There was evidence of involvement in care plans of both patients and their carers. Families and carers were given information about treatments and support available for themselves.

We observed a positive patient/carer forum where people were encouraged to raise areas of concern and give feedback on the services. The forum was well run and had excellent links with the organisation who would answer any questions raised in the forum. Patients could give regular feedback through questionnaires and surveys.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

The managers monitored any waiting times. The service had strict criteria and patients would be signposted to other services if they did not meet this criteria. The crisis service was available to people who needed extra support outside the team's normal working times. Appointment times were flexible for assessments as clinics took place daily. Care coordinators made appointments with people on their own caseloads and these were determined by patient need.

When patients deteriorated, then care coordinators would increase support and look at a referral to home treatment team. Patients were seen at least fortnightly sometimes weekly depending on need.

The east manager had started a project looking at caseload sizes in order to identify those who would be ready for discharge. The project was a new way of working that meant that each patient would receive a full assessment by a doctor, with two follow up appointments leading to discharge or long-term support.

The facilities promote recovery, comfort, dignity and confidentiality

The teams were both based within health centres and had a full range of rooms, which included staff areas, clinic rooms, and interview rooms where patients could be seen comfortably, and in private. Most patients were seen in their own homes or in the community or could be seen at the health centres if required.

Meeting the needs of all people who use the service

There was disabled access at both locations and patients could be seen in their own homes or in the community. Interpreters were available on request and information could be made available in different languages if needed.

Listening to and learning from concerns and complaints

There had been three complaints made to the service in the previous seven months of which two were partially upheld and one was not upheld. Patients knew how to make a complaint and felt able to do this. Complaints were usually made to the manager or patient experience lead. Managers listened to the persons concerns, checked the care record notes, and spoke to the care coordinator. The service would then look at what support could be put into place and how the complaint could be resolved.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

Staff were familiar with the organisations vision and values. Senior managers were known to the staff and visited the community teams every three months. Staff were represented at board level and felt able to raise concerns or suggestions. The chief executive was available to listen to staff, who felt supported by the organisation.

Good governance

Good governance systems were in place to monitor performance and clinical care. Managers monitored mandatory training compliance and identified when action was needed. All staff had ongoing supervision, which was positive and constructive.

There was good reporting of incidents and learning from these within teams. Safeguarding procedures were in place and followed by staff.

The organisation had a rolling audit programme, which was known by managers and staff working within the teams. The organisation would notify managers of any outstanding audits. The service was linked into the Clinical Audit Committee, which reported to the Clinical Governance Committee, which in turn reported to the NAViGO CIC Board.

Performance measures were in place and managers had access to up to date performance reports. The reports allowed managers to drill down to individual team member/patient level. The data warehouse collated performance which was then monitored by a corporate performance team

Quarterly performance meetings were held between the senior operational manager and senior members of the corporate team including the Associate Director of Operations Director of Finance, Performance/Audit Manager Head of Corporate Affairs. The minutes from the last meeting showed that both teams were on target with performance and finance.

The teams were well supported by managers and administration staff and items could be added to the risk register if needed. An example of this was in relation to the staffing issues seen in the east team. These had been communicated to senior managers and were included as part of the organisations risks.

Leadership, morale and staff engagement

Staffing issues were being addressed within the east team and measures were being put in place to support the team.

The 2014 staff survey was completed by 62% of staff and had the following results:

- 81% would be happy for a friend or relative to have care and treatment
- 88% felt that the care of service users was a top priority
- 79% felt that senior managers were committed to service user care
- 88% felt able to do their jobs to a standard they were happy with

We found good local management at both teams where staff felt supported to do their jobs. There were some pressures on both teams due to staffing issues but generally teams worked together to ensure that patient care was of a good standard. Team moral was good although staff did find the job stressful at times and there were challenges around covering for staff vacancies.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Mandatory training compliance was below target for safeguarding adults, safeguarding children, and information governance. This was in breach of Regulation 12 (2)(c)