# The Child and Family Practice

## Inspection 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 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.** (Previous inspection 01 2018 – Good)

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 The Child and Family Practice as part of our inspection programme.

The service provides outpatient mental health assessments and treatment for children and adults.

The consultant psychiatrist at the service is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection of The Child and Family Practice focused on the clinical treatment delivered by the consultant psychiatrist and the associated administrative support. The inspection did not look at the treatment delivered by the other clinicians who rented rooms at this location to see patients. They were either separately registered or had practising privileges with another registered provider.

**Our key findings were:**

- The service met the needs of the individual patients who were assessed and treated.
- Each patient had a comprehensive mental health assessment. The treatments provided were informed by best-practice guidance and suitable to the needs of the patients.
- The service considered the risks for individual patients and understood and acted appropriately to safeguarding concerns.
- Staff worked well together as a team and linked with relevant services outside the organisation such as the patients GP.
- Staff had access to mandatory training and supervision.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. The service actively involved patients and their families in care decisions.

# Overall summary

- The service was easy to access. Every referral received a telephone response, discussing whether the service could meet their needs or not. The service actively sought patient feedback on care.

- The service promoted a positive, patient centred culture. Leaders were competent, accessible and supportive.

However:

- Staff employment records did not include all the required information.

CQC inspected the service in January 2018 and asked the provider to make improvements regarding access to patient records belonging to other faculty members. This was not identified as a concern at this inspection because faculty members operated as independent healthcare professionals. This means that there is no requirement for them to access each other's treatment records for the purpose of shared governance processes.

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

- The service must ensure governance arrangements identify when areas for improvement are needed. This included ensuring staff pre-employment checks were completed and documented.

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

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

- The service should ensure consent to treatment is formally recorded for all patients in the patient record.
- All staff should receive an annual appraisal.
- The service should ensure policies and procedures are dated and version controlled.

**Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA**

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

## Our inspection team

Our inspection team was led by a CQC lead inspector with a CQC senior specialist completing the inspection team. The team had access to off-site support from an operations manager. The CQC lead inspector had access to advice from a specialist advisor.

## Background to The Child and Family Practice

The Child and Family Practice is a community-based independent health service that specialises in the psychological wellbeing and mental health of children, young people and adults. The service accepts self-referrals from individuals across the country and internationally. The service

conducts mental health assessments and provides treatment. Most of the patients are children and adolescents, but some adults of working age are accepted.

The service directly employs the lead consultant psychiatrist who is also the registered manager, one practice manager and two part time receptionists.

There are around 30 other clinicians, known as faculty members, who hire rooms to see patients at The Child and Family Practice. This includes psychiatrists, paediatricians, psychologists and psychotherapists. These professionals are responsible for their own clinical practice. The Child and Family Practice provides their accommodation and administrative support for when they access the service.

The organisation is a limited company with a board of directors and 13 shareholders. The registered manager is the chair of the board.

The inspection of The Child and Family Practice focused on the clinical treatment delivered by the lead consultant psychiatrist and the associated administrative support. The inspection did not look at the treatment delivered by the other clinicians as they were either separately registered or had practising privileges with another registered provider.

The service is registered with CQC to undertake the following regulated activities:

- Treatment of Disease, Disorder or Injury

**How we inspected this service**

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

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

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

During the inspection visit, the inspection team:

- Visited the service, checked the safety, maintenance and cleanliness of the premises.
- Spoke with the registered manager, the triage clinician, the practice manager and the receptionist.
- Reviewed six patient care and treatment records.
- Reviewed patient feedback.
- Reviewed three staff records.
- Looked at a range of policies, procedures and other documents relating to the running of the service.

Good

# Are services safe?

**We rated safe as Good because:**

**Safety systems and processes**

**The service had arrangements in place to keep the facilities and equipment where patients received care and treatment safe, however some recommended improvements had not yet taken place.**

- There was a process to manage infection prevention and control. Domestic staff cleaned the building daily, and we observed the environment was clean and tidy. Cleaning wipes were provided in all consultation rooms. The service did not generate any clinical waste. Personal protective equipment was available if needed.

- The provider completed a cleaning audit in September 2023. Overall compliance was 89%. There were no actions highlighted to improve performance.

- The provider had not completed a risk assessment for legionella in the water systems. Leaders submitted evidence following the inspection which gave assurance that processes had been put in place to ensure the water system was tested for legionella.

- The provider had organised for an external company to complete a fire risk assessment in January 2023, which identified areas for improvement by the next assessment date. For example, portable appliance testing (PAT) needed to be completed, electrical installation certification needed to be displayed, fire extinguishers should have been subject to annual servicing and inspection and annual testing of emergency lighting should have been completed annually. We received assurance from the provider following the inspection that some of these points had been addressed. This was a concern we raised at the last inspection.

- Staff completed mandatory health and safety training as part of their induction and refresher training. Visiting clinicians who hired rooms were given information on safety in the building.

- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Staff were trained in first aid and the process was to call emergency services in an emergency situation.

- Staff had an understanding and training for emergency procedures. For example, leaders conducted a fire drill on 25 August 2023.

**The service had systems to safeguard children and vulnerable adults from abuse.**

- Staff worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.

- Staff received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. Staff had the necessary skills and competencies appropriate for their role to identify and raise safeguarding concerns.

**Risks to patients**

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

Good

# Are services safe?

- The lead consultant carried out detailed assessments of each patient's risk at the initial assessment and continued to monitor risks at further consultations. Letters to the patients' GPs included information relating to patients' risks.

- The lead consultant identified and responded appropriately to changing risks to people who used the service. The service did not accept patients with a high level of risk or if they were unable to meet their needs. Patients were signposted to appropriate services if their risk increased to a point where they were no longer suitable for treatment at the service, and they were able to return and resume treatment if their individual risk reduced.

**Arrangements were in place to ensure that there were the right number of staff to run the service on a day to day basis.**

- There were arrangements for planning and monitoring the number and skill mix of staff. There were four members of staff employed directly by the service, including the registered manager. Monthly directors meetings took place and staffing was monitored and planned in these meetings.
- The service did not use any agency staff.

- When there were changes to services, leaders assessed and monitored the impact on safety. There were arrangements to ensure there was cover in place in the event of staff absence.

- There were appropriate indemnity arrangements in place to cover potential liabilities.

**Information to deliver safe care and treatment**

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw were comprehensive and could be accessed when required. Clinical records were in paper format and stored securely off site. Electronic patient information was stored securely on the company system and was password protected.

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, records showed there was regular detailed communication with GP surgeries, other therapists involved in patients' care and external agencies.

- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance if they cease trading. All patient records were stored securely in a locked cabinet in a locked room off site.

**Safe and appropriate use of medicines**

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

- The systems and arrangements for managing medicines minimised risks. Prescribed medicines were clearly recorded in patient records and information was shared with GPs. Physical health checks were carried out prior to prescribing medicines to patients.
- The consultant psychiatrist prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

Good

# Are services safe?

- The consultant psychiatrist accessed an online prescription service through NHS England for the prescription of controlled drugs (CDs). The doctor maintained their own prescription pad for all other medicines. The prescription pad was stored safely.

**Track record on safety and incidents**

**The service had a good safety record.**

- Service policies defined a serious incident as any that caused serious concern or potentially put a patient at risk of significant harm. The service had one serious incident in the previous 12 months. Staff responded appropriately. Staff we spoke with described the learning that had been identified and shared following the incident.

**Lessons learned and improvements made**

**The service learned and made improvements when things went wrong.**

- There was a system for recording and acting on significant events. The service had a clear incident reporting procedure. Staff understood their duty to raise concerns and report incidents and near misses. Staff documented all incidents in an incident logbook. Leaders supported them when they did so. If incidents occurred, the service escalated this for discussion at multi-disciplinary meetings to ensure learning amongst staff.

- There were adequate systems for reviewing and investigating when things went wrong. Staff learned and shared lessons and took action to improve safety in the service. For example, we saw improved processes and actions taken to protect the general safety of patients and staff on the premises following the serious incident reported by staff. Actions taken included installing a front door camera.

- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The provider encouraged a culture of openness and honesty. Staff gave affected people support, truthful information and a verbal and written apology.

Good

# Are services effective?

**We rated effective as Good because:**

**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.**

- Patients' immediate and ongoing needs were fully assessed. Staff completed detailed and comprehensive assessments of each patient. Where appropriate this included their medical history, childhood milestones, family history, school experience, physical and mental health needs. The doctor completed a full assessment of each patient at their first appointment. These assessments were updated at each appointment.

- The provider had enough information to make or confirm a diagnosis. Prior to their first appointment, patients or their parents were asked to complete a referral form providing details of their presenting concerns. Screening questionnaires were sent out to parents for autism spectrum disorder (ASD) and parents and schools for attention deficit hyperactivity disorder (ADHD). The results of these questionnaires were discussed with patients during their appointment and used to inform decisions about diagnosis and treatment.

- The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines. For example, policies and processes we reviewed were based on NICE guidance. The provider used standard screening tools for ASD and ADHD.

- The provider had systems to keep up to date with current evidence-based practice. The consultant at the service had regular communication with their supervisor and said that they were readily available for advice and support.

- Technology was used to support patients. Patients could request their appointments took place via a video call, however the consultant psychiatrist required all first appointments to be in person.

**Monitoring care and treatment**

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

- The provider used information about care and treatment to make improvements. For example, they had recently developed a written triage process, to support the staff carrying out triage duties, and to ensure patients were referred to the most appropriate clinician. The document included examples of reasons why treatment was not recommended at the service as a guidance to support staff carrying out triage duties.

- Service performance was monitored through the auditing of referrals and the patient satisfaction survey. Patient outcomes were positive in the patient records we reviewed. However, we were told it was not possible for staff to effectively monitor patient outcomes without additional funding to carry out the necessary research.

- The consultant chaired fortnightly service multi-disciplinary meetings where individual patient cases were reviewed and discussed. The consultant also participated in regular continued professional development (CPD).

**Effective staffing**

Good

# Are services effective?

**Staff had the skills, knowledge and experience to carry out their roles.**

- All staff were appropriately qualified. The provider had an induction checklist to support new starters in their roles. The checklist included tasks to complete, policies to be reviewed and familiarisation with the IT systems. The induction process required that mandatory training was completed as part of the process.
- The administrative staff had regular supervisions but had not received an annual appraisal.
- The consultant psychiatrist was registered with the General Medical Council (GMC) and was up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

**Coordinating patient care and information sharing**

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

- Patients received coordinated and person-centred care. Staff referred to and communicated effectively with other services when appropriate. For example, the consultant liaised effectively with GPs. Letters to GPs contained detailed information about diagnosis and treatment. We saw evidence of regular communication with other therapists involved in patients' care. The consultant psychiatrist communicated with schools when it was agreed by the patient and parents. The consultant psychiatrist shared recommendations on how best to support patients at school, and school staff shared information about performance and behaviour at school.
- Before providing treatment, the consultant psychiatrist at the service ensured they had adequate knowledge of the patient's health. We saw examples of patients being signposted to more suitable sources of treatment if it was deemed the service was not the most appropriate option for their care and treatment.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. Staff told us that safeguarding referrals to the local authority were uncommon. Staff provided an example of when the local authority had been contacted to raise a safeguarding concern. There were occasions where patients attended the service where safeguarding concerns had already been identified, and mitigations were in place to support the patient and their family. Staff provided examples of working with other services to ensure care was coordinated.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

**Supporting patients to live healthier lives**

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

Good

# Are services effective?

- Where appropriate, staff gave patients advice so they could self-care. For example, they provided guidance to patients on how to understand and manage their own health, including advice and support about regular sleep patterns. The consultant psychiatrist provided patients with tools to help manage their worries, and they provided leaflets which included guidance on where patients could access additional information or support.

- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs. This included mental health crisis teams, patient's own GPs and NHS hospitals.

**Consent to care and treatment**

**The service obtained consent to care and treatment in line with legislation and guidance however the parental consent was not always recorded.**

- Staff understood the requirements of legislation and guidance when considering consent and decision making. The service had a consent policy which reflected the relevant guidance and legislation. Patients voluntarily approached the service for treatment and were presumed to have the capacity to consent to treatment. We reviewed six patient records which suggested patients had given consent prior to their appointments. However, consent was only formally documented in the cases of young people whose parents were separated to ensure both parents agreed to their child's treatment, and for young people aged 16 or over where they consented to their own treatment.

- Guidance about the Mental Capacity Act was available to staff. If staff had a reason to doubt a patient's capacity they could access this policy for guidance.

Good

# Are services caring?

**We rated caring as Good because:**

**Kindness, respect and compassion**

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

- Staff sought feedback on the care patients received. Patients and their relatives were asked to complete patient satisfaction surveys after their visit. From 23 responses, 11 patients were very satisfied with their care, 11 were satisfied with their care and 1 was undecided.

- Feedback from patients was positive about the way staff treated people. The consultant psychiatrist was required to seek additional feedback from patients in July 2023 as part of the requirements of their professional registration. Feedback was highly positive, including that the consultant treated patients with respect, valued people's opinions and included them when making decisions about their care. One person commented "[The consultant] was the only doctor who genuinely supported us in the process when our own local doctors dismissed us. He took the time to listen and has offered his ongoing support to our family ever since". Another person stated "All the frustration has left [them], [they] now understand why [they] find certain things difficult, and [they] have made 2.5 years of academic progress in 7 months. [Their] friendships are easier and [their] confidence has soared. Without [the consultant] this would never have happened".

- The provider understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients. Staff gave examples of how they responded to patients' preferences and displayed a non-judgemental attitude. Records showed that the consultant engaged with patients in a holistic manner and sought to understand their lives and the things that were important to them.

- The provider gave patients timely support and information. We saw from patient feedback that the consultant psychiatrist responded promptly to emails from patients, and shared advice when they or their relatives felt concerned.

**Involvement in decisions about care and treatment**

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

- Interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.

- Patients told us through feedback to the service, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

**Privacy and Dignity**

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

- Staff recognised the importance of people's dignity and respect.

Good

# Are services caring?

- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

- Staff described how they were discreet and responsive when caring for patients. Staff said they took time to interact with patients and carers in a respectful and considerate way. Staff told us they treated all patients with respect and dignity.

- Staff ensured patient care and treatment was confidential. Patient records were stored securely.

Good

# Are services responsive to people's needs?

**We rated responsive as Good because:**

**Responding to and meeting people's needs**

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

- The provider understood the needs of their patients and improved the service in response to those needs. The provider established individual patient's needs ahead of their first appointment through the referral and triage process.

- All referrals to the service received a telephone call response, either to confirm acceptance of the referral, or explain why the service was not appropriate to meet the needs of the patient. Where necessary the provider talked through concerns and signposted families to more appropriate services. This meant that even if a referral was not accepted, patients and families felt that they had received some support.

- There was a function on the service's website and referral system that allowed patients to refer themselves directly to an individual faculty clinician. These referrals still went via the triage process to ensure the request was appropriate.

- The facilities and premises were appropriate for the services delivered. The service was situated across 4 floors, however, there was a ground floor consultation room which could be used by anyone who was unable to access the stairs. There was also a wheelchair accessible ramp that could be used to gain access to the building from the street.

**Timely access to the service**

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

- Patients had access to initial assessment, test results, diagnosis and treatment. The average waiting time for an appointment with the consultant was two months. This was in line with national guidance. National Institute for Health and Care Excellence (NICE) guidance states that no-one should wait longer than three months between being referred and first being seen for autistic spectrum disorder.

- Waiting times, delays and cancellations were minimal and managed appropriately. Appointments were available in the evenings and on Saturdays to meet the needs of patients. The consultant psychiatrist often responded to patients or families emails out of their normal working hours.

- Patients with the most urgent needs had their care and treatment prioritised. The consultant psychiatrist was clear that they were unable to accept referrals from patients who were deemed too high risk. However, there was a cancellation list, whereby patients with a more urgent need would be prioritised.

- Patients reported that the appointment system was easy to use.

**Listening and learning from concerns and complaints**

**The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.**

Good

# Are services responsive to people's needs?

- Staff made sure patients could access information about how to raise a concern or complaint. The service had received one complaint in the year leading up to the inspection. Staff treated patients who made complaints compassionately. When complaints were upheld, staff apologised to the complainant.

- Staff informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint. The consultant psychiatrist was a member of the Independent Doctors Federation (IDF) and would refer to the IDF if internal resolution could not be achieved following internal processes. The IDF would refer the complaint to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) if there were still unresolved issues.

- The service had a complaint resolution procedure in place. Staff learned lessons from individual concerns and complaints. Learning was discussed at regular team meetings and shared with all staff members.

Requires Improvement

# Are services well-led?

**We rated well-led as Requires improvement because:**

**Leadership capacity and capability;**

**Leaders had the capacity and skills to deliver high-quality, sustainable care.**

- The lead consultant psychiatrist was knowledgeable about issues and priorities relating to the quality and future of the service. They understood the challenges and were addressing them. For example, they discussed options for the location of the service as the lease for the building they ran the service from was due for renewal shortly.

- The lead consultant psychiatrist was visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership and ensured staff felt well supported. Staff we spoke with described them as approachable and personable.

- The registered manager had significant relevant clinical experience. The consultant maintained their continued professional development (CPD), which was a requirement of their professional body.

**Vision and strategy**

**The service had a clear vision to deliver high quality care.**

- There was a clear vision and set of values. These were: 'The Child and Family Practice strive to promote diversity and inclusivity in our clinical practices and services. At the Child and Family Practice, our core values align with compassion, respect, acceptance, and a working partnership with those who seek our services.'

- Staff we spoke with were aware of the patient focused vision and values of the service.

**Culture**

**The service had a culture of high-quality sustainable care.**

- Staff felt respected, supported and valued. They were proud to work for the service.

- Staff focused on the needs of patients. This focus ran through the service and was evident with all staff we spoke with.

- The provider acted on behaviour and performance inconsistent with the vision and values.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

- Leaders actively promoted equality and diversity through its vision and values. Staff felt they were treated equally.

**Governance arrangements**

**There were not always clear responsibilities, roles and systems of accountability to support good governance and management.**

Requires Improvement

# Are services well-led?

- Structures, processes and systems to support good governance and management were not always clear. The service had a fire risk assessment carried out in January 2023 by an external company. There were 7 actions identified following the assessment. However, these had not been completed at the time of the inspection. The service submitted evidence following the inspection which gave assurance that the outstanding actions from the fire safety risk assessment were being appropriately managed and addressed.

- Staff recruitment systems and processes did not always ensure that staff were suitable to employ. There was no recruitment policy or procedure in place at the time of the inspection. We discussed this with service leaders who informed us that a recruitment policy was in the process of being developed. The service provided a recruitment policy following the inspection, as well as further evidence to provide assurance that systems had been put in place to improve recruitment processes.

- Staff recruitment files did not contain all the information required. For example, we did not see evidence of proof of identification or evidence of references from previous employment. We discussed this with service leaders, who explained that this information had all been provided, however, was removed when a previous member of staff left the service. We were therefore not assured that the existing recruitment systems were effective. Staff files did not include the DBS certificate, however, they contained a disclosure snapshot, which confirmed that a DBS check had been completed.

- We reviewed 6 policies and procedures on site during the inspection. The procedures were comprehensive and reflected national guidance to help improve staff members' understanding and knowledge, however, 5 of the policies were not dated and none of the documents were version controlled to provide assurance that the documents contained the most up to date information.

**Managing risks, issues and performance**

**There were processes for managing risks and performance.**

- There was a process to identify and address current and future risks. The provider had a risk register in place, which identified actions and named the person responsible for undertaking the actions. The risk register was in place for the location where other faculty members worked separately. The main risks to the service related to staffing and the premises. However, the risks identified on the risk register were not dated, and there was no indication that the risks had been reviewed.

- Audits gathered information about enquiries to the service and patient satisfaction. We did not see evidence that clinical audit was used to improve quality of care and outcomes for patients.

- The provider had plans in place for major incidents. The service had a business continuity plan in place. This provided instruction for staff to manage and communicate unexpected events. For example, in the event of severe weather conditions which could impact on the business being able to provide its usual service.

- The provider had appropriate public liability insurance in place.

**Appropriate and accurate information**

**The service acted on appropriate information.**

Requires Improvement

# Are services well-led?

- The administrator and registered manager had access to information about the service. This included turnover, sickness data and referral information and demographics

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- Quality and sustainability were discussed in monthly directors meetings where all staff had sufficient access to information.

- Staff submitted data or notifications to external organisations as required.

- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

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

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

- Staff encouraged views and concerns from the patients. Patients had the option to share feedback following each appointment or consultation.

- Staff, patients and carers could access information about the service through the organisation's website. This included information about treatment and staff who worked at the service.

- Staff told us they were able to give feedback. As it was a small service, staff feedback was not obtained formally. However, staff we spoke with told us they were able to share feedback with leaders and that they felt listened to.

**Continuous improvement and innovation**

**There was evidence of systems and processes for learning, continuous improvement and innovation.**

- There was a focus on continuous learning and improvement. Staff were supported to attend regular Continued Professional Development (CPD). Faculty members regularly shared new research and learning from conferences.

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 17 HSCA (RA) Regulations 2014 Good governance<br><br>Systems and processes were not in place to ensure sufficient oversight of recruitment processes. Some staff pre-employment checks were not documented in staff files.<br><br>This was a breach of regulation 17 (2) (d) (i) |