Review of compliance

Leeds Teaching Hospitals NHS Trust St James's University Hospital	
Region:	Yorkshire & Humberside
Location address:	Beckett Street Leeds West Yorkshire LS9 7TF
Type of service:	Acute services with overnight beds Hospice services Rehabilitation services Community healthcare service Urgent care services Diagnostic and/or screening service
Date of Publication:	January 2012
Overview of the service:	St James's University Hospital is run and operated by Leeds Teaching Hospital NHS Trust, one of the largest

	trusts in the country, providing health care to one million people per year in Leeds and across Yorkshire. The hospital also provides a number of specialist services across the Yorkshire region and beyond. St James's University Hospital has an accident and emergency department and provides acute hospital services.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

St James's University Hospital was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 08 - Cleanliness and infection control
Outcome 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 6 December 2011, carried out a visit on 7 December 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

We spoke with people who use the service and their relatives and visitors.

People told us that the wards were very busy and there were not always enough staff. Some of the comments included:

"Staff don't have time to talk."
"Staff wouldn't be able to cope without the students."
"Sometimes not enough staff."
"Not enough staff to deal with wandering /shouting patients."
"Staffing levels vary."
"Relative does personal hygiene needs because not enough staff."
"Ward is understaffed."

However, some people said there were enough staff. Their comments included:

"Staff answer the buzzer quickly."
"Staff are approachable."
"Staff brilliant."
Staff explain everything and are friendly."
"Enough staff on the ward."
"Staff look after you well."

"Staff talk to you about your care."

Most people we spoke with were happy with the care they received. They said:

"Staff explain care and treatment"
"Staff explain what is happening and will deal with concerns."
"Staff explain what is happening and do not talk across you."
"Staff explain everything and are friendly."
"Kept well informed about care and what is happening with discharge."
"Doctors explain what is going on."

The majority of people we spoke with said they enjoyed the food at the hospital. However, one person said, "On a moist diet but by the time food is served it is dry and difficult to eat."

What we found about the standards we reviewed and how well St James's University Hospital was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

We have assessed this outcome area as a moderate concern.

The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

We have assessed this outcome area as a minor concern.

The trust has standards for hygiene and cleanliness but these are not effectively maintained and managed in all areas. The processes in place do not always promote the prevention and control of infections. There are no assurances that staff are following procedures for mattress and bed cleaning. There is inconsistent practice with the following of infection control procedures around the isolation rooms and bays

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

We have assessed this outcome as moderate concerns.

There are often times on wards 28, 29 and 34 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is always safe, effective and meets people's needs.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

In a previous review, we found that improvements were needed for the following essential standards:

- Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

In a previous review, we suggested that some improvements were made for the following essential standards:

- Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

- Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
During the last three months we have received a number of concerns from people who use the service and staff, telling us of incidences of poor care and neglect of people's needs. People said their care needs had been neglected due to lack of staff and their dignity at times compromised. People said they had been left in wet beds for prolonged periods of time and had falls due to lack of staff assistance and supervision. One person said they had seen elderly people wandering on wards in states of undress which severely compromised their dignity. Others said they were not given the help they needed to maintain their personal hygiene and the assistance they needed with eating and drinking. Staff reported that staff shortages were leading to elderly people being left wet after episodes of incontinence and being rushed with tasks.

People had also expressed concerns about spending long periods of time on trolleys in corridors on wards, waiting for admission to a bed.

At this visit to the service, we spoke to people who use the service, their relatives and visitors.

Most people we spoke with told us that the care was good and staff were helpful. People said that staff treated them with dignity and would explain what they were doing. Comments included:

"Staff explain care and treatment"
"Staff explain what is happening and will deal with concerns."

"Staff explain what is happening and do not talk across you."
"Staff explain everything and are friendly."
"Kept well informed about care and what is happening with discharge."
"Doctors explain what is going on."

The majority of people we spoke with said they enjoyed the food at the hospital. However, one person said, "On a moist diet but by the time food is served it is dry and difficult to eat." Another raised concerns that records of nutrition are not maintained properly when their relative is nutritionally at risk.

Some people told us they had been involved in decisions about their treatment and most told us staff listen to their concerns and take them seriously. Some told us they had received conflicting information from different professionals. Some people felt that not all staff would deal with concerns raised. They said:

"Difficult to get explanation of treatment – different doctors give you different information."
"Feel can raise concerns but depends which staff on duty if concerns are listened to and dealt with."
"Can raise concerns but don't know how seriously they are taken."

Other evidence
During this visit, we saw that staff treated the patients with care and dignity. Staff explained what the were doing and always pulled the curtains around the bed when providing personal care such as changing, washing and giving treatment.

Our observations of people's care showed that staff were kind and considerate. Staff delivered care sympathetically and explained what they were doing when carrying out any tasks. Care was delivered in a timely manner, we did not see people waiting for prolonged periods of times for assistance they needed.

Overall, meals were served well, staff took meals to people and arranged trays so they were in easy reach and people could manage themselves. This encouraged people's independence. However, on one ward, it was not clear which people needed assistance with their meals and what level of help was needed. We spoke with staff who told us they verbally discuss with new staff the assistance that people need at meals time. We looked at some care records and they did not give clear details of people's needs regarding assistance with meals. This could lead to people's care needs being missed or overlooked.

On another ward, we saw that the food served looked well presented and all people we spoke to confirmed that it was hot. We observed staff helping people with their meals where required. Drinks were served after the meal and people were given a choice of drinks. During the visit we observed the serving of meals and found that assistance was given to patients in an appropriate manner. For example a nurse was helping a patient who could not feed themselves. She told the patient what was on the plate and took her time feeding the patient and encouraging her to eat. However, patients were not always given opportunity to wash their hands before and after their meal and we saw some staff give assistance with feeding without washing their hands first. This issue will be addressed in outcome 8 of this report. We also saw one person had food left in front of them for 30 minutes as they were asleep. Staff walked past and didn't assist until

matron saw this and pointed it out. They were then given assistance with their meal.

We observed staff involving people in the daily routine and making choices available to them and including them in any procedures. For example we saw one patient being assisted to mobilise by the physiotherapist They were careful to explain fully what they were doing and gave plenty of time for the patient to be involved and help themselves, as much as possible.

Staff we spoke with showed a good understanding of respect and dignity. They were able to give good examples of how they try to ensure this for people who use the service. They understood the principles of person centred, individualised care.

However, most staff said they were aware of times when people's dignity has been compromised due to being short of staff. They said that people can have unnecessary episodes of incontinence as they cannot get to them in time. They said that people's personal hygiene needs are not always attended to promptly. They said it can be the afternoon before people get a wash or shower. They said that men may not get a shave every day and if they are so busy, some people may only get a 'hands and face' type wash rather than a full bed bath.

One staff said that they have, on some occasions, not had enough staff available to safely manage people's moving and handling needs in a timely manner. They said they had 'rolled' a patient who really needed the assistance of two staff and a hoist as they felt it was better to take this risk rather than wait for the assistance of another staff member. (The patient had been incontinent). This put the staff member and patient at risk. Another said that people are sat in chairs for too long when they want to get back in bed or are in uncomfortable positions in bed and have to wait for enough staff to be available to assist them.

Staff also said that when they are short of staff, they have to rush tasks and don't have time to spend with people giving them reassurance and allaying feelings of anxiety that people often have when in hospital. One staff said, "You feel like you have failed people." Another said, "Basic needs are met and priority is given to emergency care needs but you always wish you could do more." Staff said it can be difficult to supervise people who may need extra attention due to being confused or agitated. During our visit we saw that a person who had been assessed as needing one to one support did not always have this.

Another staff member said that people were missing their physiotherapy appointments because of staff shortages they were not washed and dressed in time for the appointment.

On one ward we visited, one staff member said that people who use the service had suffered falls due to lack of supervision when short of staff. We asked for an analysis of information on falls from this ward. The information showed there had been 16 incidents of falls, slips or trips reported in a four week time period. We were told that none of these incidents had resulted in serious harm for the people who sustained the falls.

Staff said that essential care such as medication, pressure area care and the carrying out of observations such as temperature and blood pressure checks are prioritised and always done.

Staff said that people who use the service receive good care when they have enough staff to provide it properly. They said they were well trained in delivering person centred care and their ward sisters and managers supported them well.

We discussed discharge planning and arrangements with some staff. Staff said that discharge can be delayed due to not having enough time to arrange it promptly. One staff said that discharge planning could be better organised but they have to wait for ward rounds to finish before they can start planning. They said this then results in delays, bed shortages and leads to the situation of people being admitted to wards and waiting on trolleys. A matron told us they try to work to the policy of people waiting on trolleys for no longer than 30 minutes.

We looked at records that are kept on 'trolley admissions' and could see that people can be waiting for a bed from three to seven hours. Staff said they try to make people as comfortable as possible during this time and they have a room available where people can be examined in private while on the trolley. Staff said this wasn't 'ideal' but they try to make the best of the situation.

In general we observed that people receive care appropriate to their needs. However, it is evident from staff and patient comments that there is sometimes a shortage of staff and that this can impact on people's care, the likelihood of patients slipping and falling, discharge planning, and on occasion their dignity can be compromised as a result. While none of these incidents appear to have caused significant harm to patients there is risk that due to staff shortages these incidents will recur. Staffing is discussed further under Outcome 13.

Our judgement
We have assessed this outcome area as a moderate concern.

The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are minor concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We did not discuss this outcome with people who use the service.

Other evidence
In October and November 2011 we received information that wards and toilets were unclean and that nursing staff had to perform cleaning duties that should be carried out by cleaning staff.

During our visit we found the wards generally in a good state of repair and all the fixtures and fittings observed were in a good state. We found commodes were clean.

On one of the wards a bay was closed due to the need to isolate the patients in this bay. We saw that the 'bay closed' sign had fallen off which meant that it was not obvious this bay area was closed and we saw a staff member enter the area with no gloves on. We discussed this with the ward sister at the time of our visit and the sign was replaced.

We looked at four bed mattresses on one of the wards. All four had staining on the foam mattresses that had penetrated the covers. We saw that one of the forms which indicates whether the mattress and bed space has been cleaned and ready for the next patient had not been completed in full. None of the nursing duties had been ticked as completed. The other three beds did not have any forms in place to say they had been checked at all. Nursing staff told us there was no space to tick on the form that the mattress should be unzipped and checked, however the matron pointed out that it was on there. None of the staff on the ward could confirm that they would unzip the mattress covers to check for stains inside the cover.There was no assurance that the nurses or

health care assistants were actually cleaning the areas they were supposed to. This issue was brought to the immediate attention of the ward sister who began making arrangements for new mattresses to be brought to the ward. They also told us that the procedure for mattress cleaning would be brought to staff's attention through a specially organised meeting and they would make sure that bed, mattress and bed space cleaning records were properly maintained in future.

After the inspection visit, the trust informed us that the staining on the mattresses had been reviewed by infection control and tissue viability nurse consultants. They had confirmed that the staining on the mattresses was discolouration due to light or heat. They also said they have gained guidance from the mattress manufacturers to assist staff in their inspections of mattresses.

Through our observation of mealtimes we saw that patients were not offered hand washing before or after meals. However, on one ward we were told that patients are given hand wipes before meals. We also saw during this time that a number of staff did not follow infection control procedures, regarding the changing of aprons and gloves. A number of staff walked in to bays and side rooms that were clearly signposted as having infection control procedures in operation. One staff walked in to the bay wearing apron and gloves that had been used for food distribution and then out again and into another side room with the same apron on. Another walked in to the bay area and out again with the same apron on. One staff kept the green apron and gloves on and went into the sluice area and came out with it still on

We also saw that two staff did not wash their hands before they fed a patient at lunchtime.

Staff told us there were good systems in place to ensure wards were clean. They said there were enough cleaning staff.

Our judgement
We have assessed this outcome area as a minor concern.

The trust has standards for hygiene and cleanliness but these are not effectively maintained and managed in all areas. The processes in place do not always promote the prevention and control of infections. There are no assurances that staff are following procedures for mattress and bed cleaning. There is inconsistent practice with the following of infection control procedures around the isolation rooms and bays

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
During the last three months we have received a number of concerns from people who use the service and staff, telling us of their concerns with regard to staff shortages. As mentioned in outcome 4 of this report, they have reported that people's care needs are being neglected due to there being insufficient staff.

We were told that a person with dementia went missing due to lack of staff supervision. We were also told that staff were not available to assist people in getting to the toilet or to change soiled bedding. People told us that they had heard staff complaining about being short staffed and not being able to use bank staff to cover shortages. Staff told us they did not have enough staff to meet people's needs and that staff were 'tired and stressed' and unable to take breaks when at work.

During our visit, people told us that the wards were very busy and there were not always enough staff. Some of the comments included:

"Staff don't have time to talk."
"Staff wouldn't be able to cope without the students."
"Sometimes not enough staff."
"Not enough staff to deal with wandering /shouting patients."
"Staffing levels vary."
"Relative does personal hygiene needs because not enough staff."
"Ward is understaffed."

However, some people said there were enough staff. Their comments included:

"Staff answer the buzzer quickly."
"Staff are approachable."
"Staff brilliant."
Staff explain everything and are friendly."
"Enough staff on the ward."
"Staff look after you well."
"Staff talk to you about your care."

Other evidence
When we last visited the service in August 2011 we said the health and welfare needs of people who use the service were not always being met because there were often insufficient staff to ensure needs were being met. We set a compliance action for them to be able to rectify the service.

The trust responded by sending us an action plan of what they were going to do to improve the service and ensure their compliance with this outcome area. They told us they had recognised the need to 'grow the nursing and midwifery workforce' and were developing the way in which they would do this. They said they had calculated the staff numbers they needed based on patient's needs and had used a nationally recognised tool to assess this. They told us that in July 2011 their vacancy rates were in the usual range they expected and that the majority of vacant posts were covered by bank staff.

Since the August inspection the trust also said that they had improved recruitment practice and sickness and absence monitoring. They told us they had improved staff deployment by introducing 'e-rostering'. (This is a computer assisted system for developing rotas.) We found during our visit that this has not yet been fully implemented on some wards. However, sisters told us they are working to the principles of e-rostering and have been trained to do so. The trust also said that from December 2011 they would be introducing new patient surveys to ask people if there had been enough nurses and said that senior staff would be reviewing staffing levels and rotas through the e- rostering system.

We spoke with a matron who told us that staff had raised concerns about staffing in one of the wards visited. They said the ward had been reviewed in order to improve staffing, leadership and care. They said they had recruited to some vacant posts in September and October 2011, audited rotas and would be introducing patient experience surveys.

As previously mentioned in outcome 4 of this report, all staff we spoke with at this visit said they were at times short staffed due to vacancies and sickness. They said they felt staffing had improved on the whole, from about September 2011 onwards in that there was an increased willingness from senior managers to provide cover from the trust's bank staff and they could see vacant posts being recruited to. However, they said it was often not possible to find staff to cover sickness, especially when there was not much notice of sickness given. Staff also told us that some bank staff are reluctant to work on wards where the work is seen as 'heavy'. They said bank staff can 'pick and choose' where they want to work. Some staff said there had been an increase recently in the numbers of staff leaving as they did not like the changes that had been made such as re-locations of wards from other hospitals and expectations of more flexible working.

The acting divisional nurse told us they have introduced a new initiative, commencing December 2011. A 'pool' of 10 bank staff are employed for each shift on a daily basis to be deployed where needed to cover staffing deficits such as last minute sickness. Documentation was provided to show this had been established and how it will work.

Some staff said they didn't think sickness absence was well managed. One staff said they had raised concerns about 'lazy' staff and staff who were frequently sick but didn't see anything change. Another said they thought this was improving and being managed better.

Most staff said they received good support from their managers. We received comments such as:

"Best sister I have ever worked for."
"Brilliant support, very approachable."
"Sister leads by her own good example."

However, some staff said they did not receive good support and guidance. They said there were issues with consistency of leadership having had a number of ward sisters in a short period of time. They also said they were often "Shattered and stressed" due to working short staffed and not being able to take adequate breaks.

One staff told us that leadership was not good on one particular ward and they had raised concerns with senior managers about this and the staffing levels with regard to rehabilitation for people who have had a stroke. They said that reduced staffing levels results in prolonged lengths of stay, reduced quality of care and dignity and can be a co- factor for health care acquired infections. (HCAI's). We asked the trust to provide us with their response to these concerns. They assured us that staffing levels on this ward had been developed, taking into account, national and regional guidance for stroke services. They also said stroke service development is under discussion at the trust board meetings. When we looked at recent rotas for this ward, we saw that staff sickness was occurring daily and they were working below the agreed numbers on 27 shifts out of 63. While this suggests that for 42% of the time over the three week period we looked at, they have functioned without a full staff complement. This in effect means usually that they may be one staff person down on a shift. This may be a qualified nurse or a clinical support worker.

Most staff said they worked in good supportive teams. However, in one area we visited staff said they had not properly established their team and sense of team as they were all new to working together. This is a ward that has been established to to provide additional capacity within the hospital to help manage operational pressures during the winter period. We saw that the sickness absence rate in this area seemed higher than in others. Some days there were up to four people sick.

Most staff said they felt their concerns about staffing levels were listened to and taken seriously. They said they complete incident reports whenever there are staff shortages and these are then investigated. We saw evidence of some of these and saw that short term staff cover from other wards was recorded and action taken such as sickness monitoring was documented. Staff said they had increased confidence in matrons who have the responsibility of ensuring safe staffing levels and understood that 'cover' cannot always be found at the last minute. They said that matrons would assess

situations of staff shortage and move people from wards that were better staffed if needed. Records on the wards did not show evidence of this and how this was managed. Matrons' daily checks showed where staff shortages had been identified but did not record what cover had been provided. The chief nurse said they would be looking at ways in which they could represent in future the cover that was provided.

We looked at rotas covering a three week period on three different wards. These showed that there were still a significant number of times when they were working below the agreed numbers of nursing and support staff. On one ward 46% of shifts were short of at least one staff member, on the other two wards it was 42.8% and 34.9% % of the shifts worked where they were one staff member below the agreed numbers. Staff told us that these shortfalls were in the main, due to staff sickness incidents. As mentioned above, the rotas did not have information recorded as to whether staff cover was provided from other wards to cover any of these deficits. On the day of our visit, they were working below agreed numbers on two out of the three wards visited. We did see that efforts were being made to try and find staff cover. However, on one ward, they had been trying for two days to find staff to cover gaps in shifts to no avail.

Staff told us that new documentation called 'patient nursing care checks' had recently been introduced. These are a self assessment to be completed by the nurse in charge of the shift. They are asked to assess whether they have met people's needs properly, if they are happy with the level of care they have provided, what has gone well and if they have identified any problems such as staffing levels that need to be reported to matrons. We saw that these were being completed and in the majority of cases staff had said they had provided care in a timely manner, despite being short of staff. We also saw that actions had been identified such as needing additional staffing due to individual patient needs and it had been recorded that this had been provided from the 'pool'.

Matrons have also introduced rota audits. We saw from these that issues regarding the planning of rotas were being addressed. For example, uneven roster shift allocation such as deficits on some shifts and surplus on others. We saw that meetings were planned with ward sisters and managers to discuss these matters.

It is evident that on the three wards we visited that they are frequently understaffed. It is also evident that since our inspection in August 2011 efforts have continued to be made to ensure sufficiency of staff at all times. Staff also said that matrons endeavour to fill staff gaps from other wards although there is not always a record of these changes. The wards we visited were Ward 28, 29 and 34 and these primarily care for elderly people. In order to ensure that the needs of elderly patients are met effectively the trusts needs to assure itself that they have sufficient staff in place to meet people's needs and also contingencies in place in the event of staff absence.

As noted under outcome 4 these staff shortages have not resulted in significant harm to patients. However, the risks to patients are heightened when these wards are routinely functioning understaffed

Our judgement
We have assessed this outcome as moderate concerns.

There are often times on wards 28, 29 and 34 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is always safe, effective and meets people's needs.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Diagnostic and screening procedures	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	Why we have concerns: We have assessed this outcome area as a minor concern. The trust has standards for hygiene and cleanliness but these are not effectively maintained and managed in all areas. The processes in place do not always promote the prevention and control of infections. There are no assurances that staff are following procedures for mattress and bed cleaning. There is inconsistent practice with the following of infection control procedures around the isolation rooms and bays	
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	Why we have concerns: We have assessed this outcome area as a minor concern. The trust has standards for hygiene and cleanliness but these are not effectively maintained and managed in all areas. The processes in place do not always promote the prevention and control of infections. There are no assurances that staff are following procedures for mattress and bed cleaning. There is inconsistent practice with the following of infection control procedures around the isolation rooms and bays	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: We have assessed this outcome area as a moderate concern. The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: We have assessed this outcome area as a moderate concern. The delivery of care is not always safe and effective. The service needs to take action to improve and maintain their arrangements for delivering care treatment and support to protect people against the risks associated with unsafe or inappropriate care, treatment or support.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met:	

	We have assessed this outcome as moderate concerns. There are often times on wards 28, 29 and 34 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is always safe, effective and meets people's needs.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: We have assessed this outcome as moderate concerns. There are often times on wards 28, 29 and 34 when there are insufficient staff, and it is difficult to get more staff quickly, to provide care that is always safe, effective and meets people's needs.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA