Review of compliance

West London Mental Health NHS Trust St Bernards and Ealing Community Services	
Region:	London
Location address:	Trust Headquarters Uxbridge Road Southall Middlesex UB1 3EU
Type of service:	Acute services with overnight beds Doctors consultation service Doctors treatment service Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Prison Healthcare Services
Date of Publication:	November 2012

Overview of the service:	The St Bernard's and Ealing Community Services location of West London Mental Health Trust (WLMHT) is registered to provide the regulated activities of assessment or medical treatment for persons detained under the Mental Health Act 1983, treatment of disease, disorder or injury and diagnostic and screening procedures.

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

Our current overall judgement

St Bernards and Ealing Community Services was not meeting one or more essential standards. Action is 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 as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 2 October 2012, observed how people were being cared for, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

During our visit we spoke to twenty seven people who use the service. These were people who were inpatients on a number of forensic wards and adult acute mental health wards at St Bernard's hospital, as well as people living in the community who use some of the community services of the Trust. This included people who use Ealing assessment team and the East and West recovery teams.

Part of our role is to monitor the rights of people who are detained under the Mental Health Act 1983 (and subsequent amendments to this). Our Mental Health Act (MHA) Commissioners have visited St Bernard's and Ealing Community Services a number of times in during 2011/2012. We looked at information from the MHA Commissioners recent visits. We also looked at information from advocates, Ealing Local Involvement Network (LINks) and written feedback from people who use Ealing community services.

We have also looked at the results of the Department of Health: Survey of NHS Staff 2011/2012 and the CQC Community Mental Health Survey 2012 (CMHS). Whilst the feedback for both of these was gained from across the trust and not at location level we have considered the findings as part of this inspection.

The majority of feedback we received from people who use the service was positive about their experience of being a patient and of being involved in their care. People who were detained under the Mental Health Act said they were informed of their rights and could generally take leave form the ward when they wanted to. Most people commented that their was enough activities to keep them occupied, though we found that these were lacking on the PICU (patient intensive care unit). We also found that privacy and dignity was not always respected in some areas we visited as part of this inspection.

We also found that, across the sites we visited of St Bernard's and Ealing Community Services, the majority of feedback from staff was that they did not feel approriately supported and listened to, which they felt had an impact on the care people received, and could put people who use the service at risk.

What we found about the standards we reviewed and how well St Bernards and Ealing Community Services was meeting them

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

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care. People who use the service were given appropriate information and support regarding their care and support.

The provider was meeting this standard.

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

People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this standard.

Outcome 06: People should get safe and coordinated care when they move between different services

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

The provider was meeting this standard.

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

There were enough qualified, skilled and experienced staff to meet people's needs.

The provider was meeting this standard.

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

People were supported by staff who received training to deliver care to an appropriate standard. However, staff did not feel appropriately supported in relation to their responsibilities, which they felt had an impact on the care people received, and could put people who use the service at risk.

The provider was not meeting this standard. We judged this had a moderate impact on

people using the service and action was needed for this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider had an effective system to regularly assess and monitor the quality of service that people received.

The provider was meeting this standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

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

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People who use the service were given appropriate information and support regarding their care and treatment. All the people we spoke with said they had the necessary information to understand their treatment and care as well as their rights in relation to being detained under the Mental Health Act 1983. Most people said that the staff were good at explaining their rights to them. The records of people being given information in relation to the Mental Health Act and being reminded of their rights were also logged in their care records.

We saw booklets and leaflets on wards about various services offered by the Trust and sources of support for people while they underwent treatment. Feedback we received from advocates within the adult mental health services was that people detained under the Mental Health Act were generally aware of their rights, but that people in hospital on an informal basis were not aware of their rights in relation to choice in taking medication and being able to leave the ward. During our visit we found that there were notices on the door to the wards telling informal people how they could leave the ward.

People expressed their views and were involved in making decisions about their care and treatment. All the people we spoke with confirmed they were involved when their needs were assessed and reviewed. Some showed us copies of their care plans, and

these had been signed by them to show their agreement. The results of our recent Community Mental Health Survey showed that most people felt their views were taken into account and that they were treated with respect.
Where people needed advocacy support, they said they were supported by their relatives or an advocate. They confirmed that an advocate was available on the adult acute wards to support them with decision making if that was required. On the adult acute mental health wards the photograph of the advocate was on display, so that people knew who to look out for. However, people in the forensic wards said that the advocate was sometimes difficult to contact and not always accessible, due to there being only one advocate for all the forensic services. This lack of advocacy services was also identified by Mental Health Act Commissioners through their visits over the previous twelve months, where they found that access to advocacy was on a referral basis only.

An advocate in the community spoke about their role in informing people of their rights and services they were entitled to access in the community. They said they were not sure if all people being discharged from hospital were aware of advocacy services. Similarly, findings from our recent survey were that approximately one third of people did not know that they could bring an advocate, friend or relative to care review meetings. During our inspection the feedback we received from people in the community was that some knew about advocacy services, and we also saw information on display in the community services of how people could access these.

People's diversity, values and human rights were respected. All people said their cultural and spiritual needs were respected and staff supported them to meet these needs. People said arrangements were made on the wards when there were cultural celebrations and festivities for them to enjoy. People had access to multi-faith rooms and religious texts. They also confirmed that culturally appropriate meals were provided. They told us that they had the opportunity to cook culturally appropriate meals on a rota basis, so that all people had an opportunity to prepare their own food. On one ward we spoke to an interpreter who had been booked by staff to translate for a person during a ward round. We also observed staff booking interpreters for other people who use the service. Staff told us that where people did not understand English they would find means to communicate with them for example by using signs and pictures.

People were supported in promoting their independence and community involvement. Comments from some people who use the service were: "..I feel very comfortable..", "..I can watch TV in my room without disturbance..". We saw that staff always knocked on people's bedroom doors before entering the rooms. Staff engaged with people on many occasions and showed respect towards people. People could go for walks and into the local community if they were not detained under the Mental Health Act. Others who were entitled to leave under the Act were supported by staff so they could plan when and where they wanted to go. However, we found on one of the forensic wards that people had to 'earn' the leave that they were actually entitled to under Section 17 of the Mental Health Act. Section 17 entitles people who are detained under the Act to take leave away from the ward for periods of time, either escorted by staff or unescorted, depending on an assessment of risk.

Other evidence
People's privacy, dignity and independence were respected. Findings from MHA

Commissioners visits over the previous twelve months to three wards were positive, where the people spoke about being respected and the staff being helpful and kind. Staff were observed being polite and courteous to people. Our MHA Commissioners also found evidence of people being involved in their care planning and their views being recorded.

During our visits to the community settings we saw that people were seen by the psychiatrist, nurse or social worker in private. Staff also spoke in a calm and friendly manner to people. We saw information displayed on the notice boards that encouraged people using the service to ask for their care plans if they wanted copies. Easy read information was also available. Leaflets displayed were also in other languages such as Punjabi and Somali. Information on local support groups was displayed for people using the service and some of the groups were run within the community base.

However, the provider should note that in St Bernard's Hospital we observed on Mary Seacole Ward (female) there were no curtains or blinds on the bedroom windows that we viewed. The signage to the Mary Seacole wards was also inaccurate and did not clearly inform people and visitors where the wards were.

In the community setting of the Ealing Assessment Team, the people we spoke with said they felt the waiting area was 'like a corridor'. We observed that there were a number of doors leading off from the waiting area with staff frequently passing through. Some of the people in the waiting area were in a distressed state, and using the waiting area as a walkway did not provide enough privacy.

Our judgement
People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care. People who use the service were given appropriate information and support regarding their care and support.

The provider was meeting this standard.

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

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Care and treatment was planned and delivered in a way that ensured people's safety and welfare. People said they were satisfied with their treatment and the care they received. One person said "..I am happy here, staff are here to help..". People said their treatment and care was decided in meetings which they were involved in. They also knew the various health and social care professionals who were involved in their care. Feedback received from our recent community survey was that most people knew who their care co-ordinator was and they felt able to contact them. However a few people did not know who to contact if they were in a crisis. Similarly, only over half the people surveyed said they had a phone number to contact someone out of hours.

People we spoke with had a clear understanding of their care plan and of the upcoming reviews of these. They said they felt listened to, though some said they found ward rounds and review meetings 'daunting' with the number of professionals present. An advocate told us that they generally felt people were listened to in ward rounds, and that people were given a choice of treatments to improve their mental health and promote their mental wellbeing.

Most people we spoke with on the wards told us about different activities they had been involved in, such as cookery sessions, beauty sessions, drumming workshops, art therapy and individual sessions with their primary nurse. Some people spoke about their work in the hospital allotment, within the grounds of St Bernard's Hospital. All the wards had direct access to a garden area as well as a communal garden for fresh air.

Other evidence
Peoples' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The care plans reflected the outcomes of review meetings and areas significant to the person, such as medication, psychotic symptoms and any substance misuse issues. There was evidence that people were involved in their care plans, with direct quotes being used. The care plans included the involvement of occupational therapists and psychologists, where a need had been identified. The support plans and risk management plans were kept under regular review and updated with the involvement of the person who uses the service. Recent findings from our MHA Commissioners visits was that considerable improvements had been identified in relation to people having individual meetings with their primary nurse, people being more involved in planning their care and improved record keeping to evidence these interactions having taken place.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. Risks to people had been identified and individualised risk management plans put into place to ensure they were safe. These included plans to minimise risks to people from their own behaviour and the behaviour of others. There were care plans in place for people who were under seclusion and regular records were made about the person's general welfare. People who were considered at significant risk were allocated a member of staff to supervise them to ensure they were safe.

However, the provider might like to note that we identified some areas of risk to people on the Patient Intensive Care Unit (PICU). Where a person posed a risk to others, this was not incorporated into their risk management plan to ensure the safety of other people. On the same unit we observed a risk where a hairdresser was using scissors to cut people's hair, with no staff presence. Similarly, on entering the ward we were not requested to go through the ward security procedures.

People received general medical services through GP services that were available on site. Staff said they referred people as required so they could see their GP. We were informed that staff had received training on resuscitation and that in cases of a medical emergency people were referred to the local general hospital.

There were activity coordinators and occupational therapists who arranged activities for people. People said they enjoyed the activities provided as these were something for them to do and relieved some of the boredom. The activities on the wards included a variety of groups and therapies that people could attend. However, we observed that on the PICU ward the activity programme included 'smoking' as an activity a number of times a day. There was no separate activity provision for people who did not smoke. We were also informed that there was no psychology input available for people on the PICU.

Our judgement
People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this standard.

Outcome 06:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
* Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
People told us there were many health and social care professionals involved in their care and they had a primary worker who coordinated their care and support. They said they found the review meetings useful as these provided an opportunity for them to meet the various professionals involved in their care, and they could all agree on an action plan and for the relevant professional to take responsibility for their area of expertise.

However, the provider might like to note that the findings of our recent survey was that more than half of the people surveyed said they did not have enough support with their physical health needs or support with their care responsibilities.

Other evidence
People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others. On one of the wards we visited the staff worked with a worker from a local mental health charity and an expert by experience to implement a specially designed recovery programme. The ward manager showed us statistics that demonstrated that, as a result of this, there had been significant improvements to people who use the service through the reduction of incidents of self-harm as well as incidents between people who use the service.

Staff responsible for the admission and discharge of people in the hospitals told us they worked with outside bodies, such as the police, in planning emergency admissions of

people.

Staff who worked in the community services said they received relevant information from the hospital prior to people being discharged into their care. This was through a system of computerised records management used by the trust to enable various teams to record the care and treatment people received and to communicate about people's needs.

The computerised care planning system was shared between the community team and the acute hospital team to enable access to the records of people. Community staff said they also attended review meetings and were involved in the care plan of people transferring into the community. Some staff in the community told us about being invited to these reviews at the hospital, yet these not being well co-ordinated. They told us that they were left "..waiting for hours.." before being invited into the meeting. Examples given were typically that they were invited for a meeting at 10am, yet did not go into the meeting until an hour or two later. They said their were also concerns about the impact this had on people who use the service, as they were also kept waiting and not able to leave the ward if they wanted to.

Some operational staff working in the community said that it was not always easy to admit people into hospital from the community. For example, after a decision involving various professionals in the community had been made to admit people to hospital because of their poor mental health, the person was often discharged back to the community at short notice.

Staff in the community spoke about their role in liaising with different services so people could access the support they needed/seek the most appropriate support for people. This included dealing with housing and mental health providers, GPs and counselling services. We saw evidence that peoples' GPs were sent copies of the care plans after review meetings took place. Staff spoke about various arrangements to inform GPs of the restructuring of the Trust and of their increased roles within this process so they were clear of their role in monitoring people with mental health needs in the community.

Our judgement
People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

The provider was meeting this standard.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
There were enough qualified, skilled and experienced staff to meet people's needs. Feedback from the majority of people we spoke with was very positive about the staff, who they described as "..supportive.." and "..available.." Most of the people we spoke to told us that they felt there was enough staff to support them. They said staff had time to spend with them, and we saw this happening during our inspection. People in the hospital who were detained under the Mental Health Act told us that through forward planning they were mostly able to take their Section 17 leave when they wanted to. Some people said they sometimes had opportunities to take leave but were not always able to go at the agreed time. People said that most of the time there were enough staff so they could go out to smoke.

Other evidence
There were enough qualified, skilled and experienced staff to meet people's needs. Staff in the hospital wards said they felt there were generally enough staff on duty to meet people's needs. Findings by Mental Health Act Commissioners were that improvements had been made to the facilitation of leave for people who use the service. They also commented that the level of staffing was stable with bank staff covering extra duties arising from escorting or observation. During our visit we carried out an analysis of the staffing levels on three of the wards we visited. Information we requested for one other ward was not provided to us. Also, bank staff figures we requested were not provided for one ward. Our overall findings were that the wards were meeting their staffing level targets for 96- 100% of the time. We also identified that on each of the wards where full figures were provided, approximately one third of the

staff who worked shfits were made up of bank staff.

The provider might like to note that we received feedback from a number of sources that there was not enough staff within the community services to provide a quality service. We spoke to Ealing LINKs, staff in the community settings including community psychiatric nurses (CPNs) consultants and social workers. They felt that since recent changes to community services and with more changes on the way, there would not be sufficient staff to provide a quality service to people. They said they were worried about the risks to people and because of the reduced amount of time they had for people using the service. They spoke about having large caseloads and feeling 'overwhelmed' by the changes to their work.

Our judgement
There were enough qualified, skilled and experienced staff to meet people's needs.

The provider was meeting this standard.

Outcome 14:
Supporting workers

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 competent staff.

What we found

Our judgement

The provider is non-compliant with Outcome 14: Supporting workers. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People generally felt that their needs were being met by appropriately qualified staff. Some people said that nursing and care staff were competent and knew how to talk to them and care and support them appropriately, whereas other staff were "..not so good..". As a result some people said they did not feel confident that they could talk about their issues with staff or that they would receive the necessary support from them.

Other evidence
Staff received appropriate professional development. Staff in all the wards told us they received training to keep themselves up to date and to maintain their professional registration. They told us the training was monitored Trust wide and they could access other training which they identified to their managers as relevant to their professional development. Staff from the community and the hospital told us they had monthly supervisions with their line managers and staff meetings so they had an opportunity to discuss issues about their work and personal development.

The Department of Health: Survey of NHS Staff 2011/2012 found that West London Mental Health Trust was in the worst 20% compared to other trusts for key findings that included staff job satisfaction, percentage of staff experiencing discrimination at work in the last 12 months, percentage of staff agreeing that their role makes a difference to people and effective team working. During our inspection we found that whilst most staff said they received good support from their immediate managers, many said they felt that more senior managers did not listen to their concerns and did not consult them when changes were introduced and implemented. One member of staff said, "when we

give our feedback to management nothing happens". As a result many said they felt insecure, unsupported and worried for their future to an extent that they wanted to leave their job, or they felt de-motivated to do the work they were doing. Some staff spoke of a 'culture of fear' and feeling bullied. All staff who raised concerns said they were worried about the impact this had on their ability to provide a quality service, and that as a result, people could be put at risk. Some staff felt that the environment within the organisation was chaotic due to ongoing changes to service delivery, though some said they felt management had improved in notifying and involving staff.

Senior managers told us of actions they had implemented a policy to be more 'visible' by going onto the wards, holding 'listening events', plus Trust-wide groups and forums that staff could use to raise issues. Some staff were aware of these forums, though some were sceptical about the change that could be effected through these.

Our judgement
People were supported by staff who received training to deliver care to an appropriate standard. However, staff did not feel appropriately supported in relation to their responsibilities, which they felt had an impact on the care people received, and could put people who use the service at risk.

The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People who use the service and their representatives were asked for their views about their care and treatment and they were acted upon. The majority of people we spoke with reported feeling safe and very aware of how they could make complaints. Some people told us they completed satisfaction questionnaires electronically to give their views on the quality of services provided. The data was analysed and shared with the ward, managers and clinical governance group to monitor the pattern and trends about people's level of satisfaction on a particular ward. Each ward had their own action plans to address areas where improvement was required. The community teams we visited told us about plans to introduce the electronic monitoring tools in each of the settings, to enable people to give feedback whenever they visited.

There were a number of arrangements so people could contribute to the way the service was provided at various levels. There were meetings at ward level, unit level and Trust level with people using the service involved at each level to make suggestions and share their views about the provision of the service. In the community there were service user forums. The minutes of these showed that changes to the community services were discussed with them and their feedback to this passed to senior managers within the trust. The minutes showed that senior managers of the trust also involved in these meetings. The feedback from the meetings was used as part of the clinical governance meetings that are held throughout each ward and community service within the trust.

During our visit to St Bernard's Hospital we took the opportunity to attend the service

user forum for inpatient people to raise issues which were important to them, such as heating, the quality of food and towels. Some people on the wards also talked about a lack of fresh fruit and healthy options for snacks. We were made aware that some of the issues raised had been ongoing, and some people said it was not clear now the Trust responded to these, especially in relation to the food provided.

Other evidence
The provider had an effective system to regularly assess and monitor the quality of service that people received. On the wards we visited we saw evidence of the auditing of care plans, infection control, mattress checks, incident reporting and audits of the forms relating to medication administered to people who were detained under the Mental Health Act 1983 to ensure the safety of people and to make sure they receive safe and appropriate care.

On one ward we visited the staff spoke about changes that had taken place, which had resulted in reducing the number of incidents, through the implementation of weekly meetings between staff and people who use the service. Staff also informed us that there were a number of quality initiatives within the Trust to monitor the quality of the service. For example there were infection control audits, care records audits and environment audits. There were also clinical improvement group and clinical governance grounds where staff looked at initiatives to improve the standard of treatment and care people received.

The managers we spoke with on the wards and in the community had regular performance meetings with their line managers, which focussed on the operational side of delivering the service.

The Trust had a team that monitored and investigated serious incidents and complaints. The Director of Clinical risk (local services) told us that they use the findings of these, to audit services and make changes to improve these. Complaints and investigation reports had resulted in changes to the practice of some wards and performance management of staff who had been found to be at fault.

Our judgement
The provider had an effective system to regularly assess and monitor the quality of service that people received.

The provider was meeting this standard.

Action
we have asked the provider to take

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting workers
	How the regulation is not being met: People were supported by staff who received training to deliver care to an appropriate standard. However, staff did not feel appropriately supported in relation to their responsibilities, which they felt had an impact on the care people received, and could put people who use the service at risk.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting workers
	How the regulation is not being met: People were supported by staff who received training to deliver care to an appropriate standard. However, staff did not feel appropriately supported in relation to their responsibilities, which they felt had an impact on the care people received, and could put people who use the service at risk.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting workers
	How the regulation is not being met:	

	People were supported by staff who received training to deliver care to an appropriate standard. However, staff did not feel appropriately supported in relation to their responsibilities, which they felt had an impact on the care people received, and could put people who use the service at risk.

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 7 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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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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