## University Hospitals of Morecambe Bay NHS Trust
### Furness General Hospital

<table>
<thead>
<tr>
<th>Region:</th>
<th>North West</th>
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</thead>
<tbody>
<tr>
<td>Location address:</td>
<td>Furness General Hospital</td>
</tr>
<tr>
<td>Type of service:</td>
<td>Acute Hospital</td>
</tr>
<tr>
<td>Regulated activities provided:</td>
<td>Treatment of Disease Disorder or Injury, Surgical Procedures, Diagnostic and Screening Processes, Maternity and Midwifery Services</td>
</tr>
<tr>
<td>Type of review:</td>
<td>Responsive review</td>
</tr>
<tr>
<td>Date of site visit (where applicable):</td>
<td>29/06/2010</td>
</tr>
<tr>
<td>Name of site(s) visited (where applicable):</td>
<td>Furness General Hospital</td>
</tr>
<tr>
<td>Date of publication:</td>
<td>September 2010</td>
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### Information for the reader

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
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<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Audience</td>
<td>The general public</td>
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<tr>
<td>Further copies from</td>
<td>03000 616161 / <a href="http://www.cqc.org.uk">www.cqc.org.uk</a></td>
</tr>
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### Care Quality Commission

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<th><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></th>
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<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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<td>Postal address</td>
<td>Care Quality Commission</td>
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<td></td>
<td>Citygate</td>
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Introduction to our 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 that 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. This is called *Guidance about compliance: Essential standards of quality and safety*.

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

When we make our judgements about whether services are meeting essential standards, we will 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, compliance actions or take enforcement action:

<table>
<thead>
<tr>
<th>Improvement actions</th>
<th>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.</th>
</tr>
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<tbody>
<tr>
<td>Compliance actions</td>
<td>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.</td>
</tr>
<tr>
<td>Enforcement actions</td>
<td>These are actions we take using the criminal and/or civil procedures in the Health and Adult 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.</td>
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How this report is presented

On page 5 below, there is a summary that shows whether the essential standards about quality and safety that were checked during this review of compliance are being met. The section on each outcome is set out in this way:

<table>
<thead>
<tr>
<th>Outcome XX (number and title)</th>
<th>Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Whether the service provider is compliant, or whether we have minor, moderate or major concerns about their compliance</strong></td>
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</table>

Following the summary, there is a detailed section on the outcomes for each of the essential standards that we looked at. The evidence that we used when making our judgements for each one is set out in the following way:

**Outcome XX (number): Outcome title**

Details of the outcome, taken from our *Guidance about compliance: Essential standards of quality and safety*.

**What we found for the Outcome**

**Our judgement**

Our judgement about whether the <service/provider> meets the outcome described in the *Guidance about compliance: Essential standards of quality and safety*, or whether there are minor, moderate, or major concerns in relation to compliance.

**Our findings**

A summary of the evidence and findings used to reach our judgement, related to regulated activities as appropriate.

At the end of the report you will find details of:

- Any improvement and/or compliance action(s) that the service provider should make to maintain or achieve compliance with the essential standards of quality and safety.
- Any formal enforcement action that we are taking against the service provider.
Summary of findings for the essential standards of quality and safety

The table below shows the judgement that we reached for each of the essential standard outcomes that we reviewed.

<table>
<thead>
<tr>
<th>Outcome</th>
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<tr>
<td>4: Care and welfare of people who use services</td>
<td>Compliant</td>
</tr>
<tr>
<td>6: Cooperating with other providers</td>
<td>Compliant</td>
</tr>
<tr>
<td>13: Staffing</td>
<td>Compliant</td>
</tr>
<tr>
<td>14: Supporting workers</td>
<td>Compliant</td>
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<tr>
<td>16: Assessing and monitoring the quality of service provision</td>
<td>Compliant</td>
</tr>
<tr>
<td>21: Records</td>
<td>Compliant</td>
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Summary of key findings:

- This responsive review was undertaken at the maternity unit of Furness General Hospital as a follow up to ongoing discussions with the trust with regards to services and care provided to mothers and babies in the unit. An unannounced visit was made to the maternity unit of Furness General Hospital on the 29th June 2010.

- We found that the trust have developed new documentation for both mothers and babies which follow them through all units in maternity and on discharge. These documents are specially designed so the ‘at risk’ mothers and babies are clearly identified. There is now a more robust system in place for multi-disciplinary working between all staff in the unit.
• The trust has achieved level 2 in the NHSLA maternity clinical risk management standards 2009/10 for managing risk.

• In discussions with staff it was confirmed that there is now a more close working relationship between the midwives and the medical staff in addressing issues where concerns are identified.

• The trust has produced a Midwifery Action plan for 2009 – 2012 which details the vision of maternity services over the next three years.

• We found that the trust has undertaken a full review of staffing within all their midwifery units and have implemented changes and developed an action plan to address shortfalls which were identified. The trust is committed to recruiting more midwives to their service.

• On the day of the review we found there were adequate numbers and grades of staff on duty within the maternity unit at Furness General Hospital.

• It was confirmed in interviews with staff that supervision and appraisals were now more formalised. Each member of staff interviewed confirmed that they received regular supervision from a midwifery supervisor and have undergone a formal appraisal where their development needs were discussed.

• There is a designated midwife with the responsibility for risk management within the maternity unit. Processes are in place for reviewing and learning from clinical incidents

• We found evidence that audits are undertaken to ensure care records are completed correctly. Findings from these audits are reported back to staff and through management structures.
What we found for each essential standard of quality and safety

The section below details the findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

Further detail about each of the outcomes described below can be found in the Guidance about compliance: Essential standards of quality and safety.
Outcome 4:
Care and welfare of people who use services

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

This is because providers who comply with the regulations will:
- Reduce the risk of people receiving unsafe or inappropriate care treatment and support by:
  - assessing the needs of people who use services
  - planning and delivering care, treatment and support so that people are safe, their welfare is protected and their needs are met
  - taking account of published research and guidance
  - making reasonable adjustments to reflect people's needs, values and diversity
  - having arrangements for dealing with foreseeable emergencies.
What we found for Outcome 4

Our judgement

The provider is compliant with outcome 4: Care and welfare of people who use services

Our findings

This unannounced responsive review was undertaken at the maternity unit of Furness General Hospital as a follow up to ongoing discussions with the trust with regards to services and care provided in the maternity unit.

An unannounced visit made to the maternity unit of Furness General Hospital on the 29th June 2010 identified that the trust had made improvements to the identification of risk for mothers and babies in their care. When undertaking the review of this outcome we interviewed 6 members of staff and spoke to 2 patients on the maternity unit. We also reviewed documentation supplied by the unit which supported the findings.

On the day of the review the trust produced, as evidence, new documentation which is being used in the unit. Birth notes have been designed by a national independent company and are colour coded to follow mother and baby through ante natal, labour and post natal periods. Both mother and baby have their own set of notes detailing care. These notes are transferred between the various wards on the maternity unit and then accompany mother and baby home on discharge or on transfer to another unit/trust if required. The design of these notes clearly identify risk factors for both mother and baby which are always immediately visible to staff. The trust has also developed new neonatal observation charts which record babies vital signs from 1 hour post birth until staff are satisfied that signs are within normal range. They have also implemented use of the ‘physiological observation track and trigger system’ as an early warning sign for complications which may occur. The traffic light system for intrapartum risk assessment has also been developed to identify risk and promote the working relationships between the multi disciplinary team and women in the trust’s care. The trust has gained level 2 in the NHSLA maternity clinical risk managements standards 2009/10 for managing risk.

The trust has a midwifery action plan (2009 – 2012). Theme one within this plan gives a clear commitment that the trust will improve the care given to high risk mothers by producing individual care plans which will be written with mothers and audit of care plans to ensure standards are met. There is also a further commitment to use the new maternity records to support collaborative working for women with complex needs.

In discussions with staff it was confirmed that there is now a more close working relationship between the midwives and the medical staff in addressing issues where concerns are identified. The use of the new documentation is identifying at risk mothers and babies more easily and clearly identify what the risks are.

Advances had been made with working with another maternity unit in the north west which encouraged staff from each of these units to share work arrangements, protocols etc and to learn from each other.

From interviews with patients it was confirmed that both felt they were well supported.
throughout their care in the unit, had enough information supplied and that both midwives and doctors knew all details about their care requirements. Review of patient satisfaction survey also demonstrated that, in the main, all respondents were very happy with the care they received within the trust.
Outcome 6:
Cooperating with other providers

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.

This is because providers who comply with the regulations will:

- Cooperate with others involved in the care, treatment and support of a person who uses services when the provider responsibility is shared or transferred to one or more services, individuals, teams or agencies.
- Share information in a confidential manner with all relevant services, individuals, teams or agencies to enable the care, treatment and support needs of people who uses services to be met.
- Work with other services, individuals, teams or agencies to respond to emergency situations.
- Support people who use services to access other health and social care services they need.
What we found for Outcome 6

Our judgement

The provider is compliant with Outcome 6: Cooperating with other providers

Our findings

This unannounced responsive review was undertaken at the maternity unit of Furness General Hospital as a follow up to ongoing discussions with the trust with regards to services and care provided in the maternity unit. There was concern that the maternity unit at Furness General Hospital was not compliant to this outcome. Information brought to the attention of CQC detailed issues with regards to multidisciplinary working and joint meetings being embedded into the maternity unit culture.

An unannounced visit made to the maternity unit of Furness General Hospital on the 29th June 2010 identified that the trust had made improvements to multi-disciplinary working arrangements on the unit. When undertaking the review of this outcome we interviewed 6 members of staff and spoke to 2 patients on the maternity unit. We also reviewed documentation supplied by the unit which supported the findings.

On the day of the review the trust produced, as evidence, minutes from multidisciplinary team meetings within the unit. This demonstrates that all staff are now working under a common and agreed way of working to promote safe and effective care.

Within the midwifery action plan 2009 – 2012 core vision 5 highlights the principle that the trust will work with partners for the benefit of patients.

In interview with staff it was confirmed that the working relationship between midwives and medical staff has improved and it is now easier to identify and share concerns. The new care documentation requires all staff to record their interactions with patients therefore giving a more complete picture of the whole care journey. Midwives are now able to ask for assistance from medical staff with more confidence.

There is a transfer policy in place and staff know how to arrange transfer between different NHS units. If a patient is transferred out of the trust then all notes are copied and sent with patients.

Evidence was produced of a multi disciplinary away day with the objectives on sharing good practice, development of staff and understanding common conditions which could have an impact on a woman’s pregnancy and managing change.

Based on the unit, there is an educational coordinator/grade 7 midwife who is responsible for focusing on undergraduate medical students learning module of midwifery/obstetrics. The development of this role has improved the working relationships and understanding between medical students, doctors and midwives.

Advances had been made with working with another maternity unit in the north west which encourages staff from each of these units to share work arrangements, protocols etc and to learn from each other.

Patients further confirmed that they felt that all staff knew about their care when being
transferred from the labour ward to the maternity ward and that their treatment records were transferred with them.
Outcome 13: Staffing

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

This is because providers who comply with the regulations will:
- Make sure that there are sufficient staff with the right knowledge, experience, qualifications and skills to support people.
What we found for Outcome 13

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

This unannounced responsive review was undertaken at the maternity unit of Furness General Hospital as a follow up to ongoing discussions with the trust with regards to services and care provided in the maternity unit. There was concern that the maternity unit at Furness General Hospital was not compliant to this outcome as there were concerns as to the grades, numbers and training of staff on duty.

An unannounced visit made to the maternity unit of Furness General Hospital on the 29th June 2010 identified that the trust had made improvements to staffing arrangements on the unit. When undertaking the review of this outcome we interviewed 6 members of staff and spoke to 2 patients on the maternity unit. We also reviewed documentation supplied by the unit which supported the findings.

Staffing rotas were evidenced for the labour and maternity wards. These rotas identified current staffing levels pertaining to early, late and night shifts. In explanation it was confirmed that grade 7 midwives are always in charge of the labour ward and a grade 6 or above on the maternity ward. Review of the staff rota however did not clearly identify grades of staff that were actually on duty. It was confirmed however, that new templates for rotas were being developed which does record grades and this is to be introduced into the maternity unit.

It was agreed that staffing could be a problem especially when the unit was very busy. This scenario cannot be pre-planned for due to the nature of the care. Contingency plans are in place to ensure extra staff are brought onto the unit when required. Staff are transferred in from the maternity ward and community based midwives to ensure correct numbers are maintained. There is a senior midwife responsible for ensuring that wards are adequately staffed and is responsible for drafting in extra staff as required.

The unit has undertaken the birth rate plus analysis which has identified that there is a shortage of midwives for the unit. It was confirmed by evidence of a Chief Executives group agenda that the trust is committed to filling these roles. The trust has now introduced birth rate accuity – which is an audit tool that looks at staff numbers and patient dependency every 4 hours. Outcomes from the findings of this planning tool will be used to ensure that staff are where they are needed at critical times. Midwifery staff interviewed confirmed that staff numbers and skills were usually sufficient to support the unit’s requirements.

There are four matrons employed across the three maternity units within the trust who are working closely with the maternity staff recruitment problem and delivering change in the way all units work.

It was confirmed that the unit does maintain 1:1 care during established labour and patients interviewed supported this statement. Patient feedback demonstrated that mothers
and their partners felt well supported throughout their labour experience and should the midwife leave the room mothers knew how to contact them, and a quick response was always guaranteed.
Outcome 14:  
Supporting workers

People who use services: 
- Are safe and their health and welfare needs are met by competent staff.

This is because providers who comply with the regulations will: 
- Ensure that staff are properly supported to provide care and treatment to people who use services. 
- Ensure that staff are properly trained, supervised and appraised. 
- Enable staff to acquire further skills and qualifications that are relevant to the work they undertake.
What we found for Outcome 14

Our judgement

The provider is compliant with Outcome 14: Supporting workers

Our findings

This unannounced responsive review was undertaken at the maternity unit of Furness General Hospital as a follow up to ongoing discussions with the trust with regards to services and care provided in the maternity unit. There was concern that the maternity unit at Furness General Hospital was not compliant to this outcome as there were concerns as to the appraisal, supervision and training of staff.

An unannounced visit made to the maternity unit of Furness General Hospital on the 29th June 2010 identified that the trust had made improvements to staffing arrangements on the unit. When undertaking the review of this outcome we interviewed 6 members of staff and spoke to 2 patients on the maternity unit. We also reviewed documentation supplied by the unit which supported the findings.

Theme four of the maternity action plan 2009 – 2012 shows the trusts priorities in strengthening and promoting statutory supervision of midwifery and to provide opportunities for development of individuals to ensure best outcomes for women and their babies.

The trust has produced a mandatory training matrix which clearly identifies what training certain staff members are required to undertake. There was evidence that a training record spreadsheet was maintained for the unit.

It was confirmed in interviews with staff that supervision and appraisals were now more formalised. Each member of staff interviewed confirmed that they received regular supervision from a midwifery supervisor and have undergone a formal appraisal where their development needs were discussed. Staff further confirmed that they could access training as required but this may have an impact on staffing levels on the unit. Midwifery supervisors are on call at all times and the wards hold their own ward meetings and drop in sessions where all grades of staff can seek support.
Outcome 16: Assessing and monitoring the quality of service provision

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.

This is because providers who comply with the regulations will:
- Monitor the quality of service that people receive.
- Identify, monitor and manage risks to people who use, work in or visit the service.
- Get professional advice about how to run the service safely, where they do not have the knowledge themselves.
- Take account of:
  - comments and complaints
  - investigations into poor practice
  - records held by the service
  - advice from and reports by the Care Quality Commission.
- Improve the service by learning from adverse events, incidents, errors and near misses that happen, the outcome from comments and complaints, and the advice of other expert bodies where this information shows the service is not fully compliant.
- Have arrangements that say who can make decisions that affect the health, welfare and safety of people who use the service.
What we found for Outcome 16

Our judgement

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

Our findings

This unannounced responsive review was undertaken at the maternity unit of Furness General Hospital as a follow up to ongoing discussions with the trust with regards to services and care provided in the maternity unit. There was concern that the maternity unit at Furness General Hospital was not compliant to this outcome as there were concerns as to multidisciplinary working and incident reporting in the maternity unit culture.

An unannounced visit made to the maternity unit of Furness General Hospital on the 29th June 2010 identified that the trust had made improvements to multi-disciplinary working arrangements on the unit. When undertaking the review of this outcome we interviewed 6 members of staff and spoke to 2 patients on the maternity unit. We also reviewed documentation supplied by the unit which supported the findings.

There is a designated midwife with the responsibility for risk management within the maternity unit. Minutes from the women's health department clinical incidents group show that all incidents which occur in the unit are brought to this panel for review. Attendances at these meetings demonstrate that it is made up from a multi disciplinary staff.

The trust also maintains a CHKS maternity dashboard for quality and safety indicators. The modern matrons are involved in root cause analysis of incidents and complaints and within the maternity action plan 2009 – 2012 there is the commitment that root cause analyses will be disseminated to all matrons and supervisors of midwives for sharing and learning of lessons.

Evidence was produced of a multi disciplinary away day with the objectives on sharing good practice for the management of pregnancy and birth.

A programme of quality assessment audits has been implemented by the trust on a rolling basis throughout all maternity units. Outcomes from these assessments are matched across to the Care Quality Commissions essential standards and requirements of the NHSLA.

There is a requirement that band 7 midwives review three sets of patient notes per month with regards to completion of records. Major concerns are reported to the relevant supervisor and matron. The head of midwifery ultimately receives copies of the outcomes from these audits.

Patient satisfaction surveys are undertaken and reports are produced with outcomes identified. On review of the report from the last survey it demonstrated that all respondents were very happy with the care and treatment they received.

In interviews with staff it was confirmed that all staff were aware of the trust’s whistle blowing policy and felt they would be supported if they had to report any concerns to managers. It was agreed that the trust does maintain a no blame culture for reporting
incidents.
Outcome 21: Records

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

This is because providers who comply with the regulations will:

- Keep accurate personalised care, treatment and support records secure and confidential for each person who uses the service.
- Keep those records for the correct amount of time.
- Keep any other records the Care Quality Commission asks them to in relation to the management of the regulated activity.
- Store records in a secure, accessible way that allows them to be located quickly.
- Securely destroy records taking into account any relevant retention schedules.
What we found for Outcome 21

Our judgement

The provider is compliant with Outcome 21: Records

Our findings

This unannounced responsive review was undertaken at the maternity unit of Furness General Hospital as a follow up to ongoing discussions with the trust with regards to services and care provided in the maternity unit. There was concern that the maternity unit at Furness General Hospital was not compliant to this outcome as there were concerns as to responsibility for completing records in the maternity unit

An unannounced visit made to the maternity unit of Furness General Hospital on the 29th June 2010 identified that the trust had made improvements to multi-disciplinary working arrangements on the unit. When undertaking the review of this outcome we interviewed 6 members of staff and spoke to 2 patients on the maternity unit. We also reviewed documentation supplied by the unit which supported the findings.

There is a requirement that band 7 midwives review three sets of patient notes per month with regards to completion of records. Major concerns are reported to the relevant supervisor and matron. The head of midwifery ultimately receives copies of the outcomes from these audits. A copy of the record keeping audit responsibilities was available as evidence.

On the day of the review the trust produced, as evidence, new documentation which is being used in the unit. Birth notes have been designed by a national independent company and are colour coded to follow mother and baby through ante natal, labour and post natal periods. Both mother and baby have their own set of notes detailing care. These notes are transferred between the various wards on the maternity unit and then accompany mother and baby home on discharge or on transfer to another unit/trust if required. The design of these notes clearly identify risk factors for both mother and baby which are always immediately visible to staff.

There is a transfer policy in place. Staff were able to confirm they were aware of the requirements to transfer either original notes or photocopies of notes as required. These new booklets are less likely to be misplaced during transfer.
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.

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<th>Regulated activity</th>
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<th>Outcome</th>
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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 report should be sent within <28 days/14 days/7 days> of this report being received.

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.

<table>
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<th>Regulated activity</th>
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</tbody>
</table>

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 <28 days/14 days/7 days> of this report being received.

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.
Enforcement action we are taking

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
<th>Outcome</th>
<th>Timescale (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter activity</td>
<td>Reg_no_or_Section_Act</td>
<td>Enter_outcome_no.</td>
<td>Enter_timescale</td>
</tr>
<tr>
<td>How the regulation or section is not being met:</td>
<td>The outcome for people that should be achieved:</td>
<td>To be met by:</td>
<td></td>
</tr>
<tr>
<td>Add &quot;what&quot;</td>
<td>Add &quot;why&quot;</td>
<td>DD_MM_YYYY</td>
<td></td>
</tr>
</tbody>
</table>