Review of compliance

Berkshire Healthcare NHS Foundation Trust	
Region:	South East
Address:	2nd and 3rd Floors, Fitzwilliam House Skimped Hill Lane Bracknell Berkshire RG12 1LD
Type of service:	Hospital services for people with mental health needs, and/or learning disabilities, and/or problems with substance misuse
Date the review was completed:	11 March 2011
Overview of the service:	Berkshire Healthcare NHS Foundation Trust provides local specialist care for people with ongoing or complex mental health issues, substance misuse issues and some learning disabilities. Care is mainly provided through local community teams who offer treatment and support through a wide range of services with links to local partnerships. The trust is registered to provide services at seven locations across Berkshire and one in Oxfordshire.

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

What we found overall

We found that Berkshire Healthcare NHS Foundation Trust was not meeting one or more essential standards. We are taking further action to protect the safety and welfare of people who use services.

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

Why we carried out this review

We carried out this review because provider level concerns were identified, during a review of one of the trust's locations, in relation to:

- Safeguarding people who use services from abuse
- Requirements relating to workers
- Assessing and monitoring the quality of service provision
- Notification of other incidents

How we carried out this review

We reviewed the information we hold about this provider. We used a range of information and evidence from various sources, this included additional information from the provider, reports made to us by the National Patient Safety Agency (NPSA) and information from local authority safeguarding teams. We carried out a visit on 08 February 2011 and sampled the provider’s recruitment records.

What people told us

We did not speak with patients or their relatives as part of this responsive review. However, we did speak to a member of one of the Berkshire safeguarding authorities to help inform our review.

What we found about the standards we reviewed and how well Berkshire Healthcare NHS Foundation Trust was meeting them

Outcome 7: People should be protected from abuse and staff should respect their human rights

The trust has not made suitable arrangements to ensure that patients are safeguarded against the risk of abuse, is not taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and is not responding appropriately to allegations or incidents of abuse.

- Overall, we found that improvements are needed for this essential standard.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The trust does not have effective recruitment procedures to ensure that people, employed to carry on the regulated activity, are of good character and the trust does not ensure that all information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 is obtained and available in respect of people employed.

- Overall, we found that improvements are 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 trust has not developed and put in place effective systems that enable the registered person to regularly assess and monitor the quality of the services provided in carrying on of the regulated activities against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, or to identify, assess and manage risks related to the health, welfare and safety of patients and others who may be at risk.

There is no effective system in place, at trust or location level, that enables the trust to identify, monitor and analyse individual incidents of patient to patient abuse for trends or for risks to patients from incidents of patient to patient abuse that result in, or have the potential to result in, harm to another patient.

- Overall, we found that improvements are needed for this essential standard.

Outcome 20: The service should notify the Care Quality Commission, without delay, of important events that affect patients' welfare, health and safety.

The trust has failed to notify the Commission (or National Patient Safety Agency), without delay, of incidents specified in regulation 18 (1) and (2)(b)(e) of the Care Quality Commission (Registration) Regulations 2009.

- We are taking further action to protect the safety and welfare of people who use services.

Action we have asked the service to take

We have asked the provider to send us a report, in relation to Outcomes 7, 12 and 16, 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.

We are taking further action to protect the safety and welfare of people who use services in relation to Outcome 20.

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 7:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are moderate concerns with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We did not speak with patients as part of the review of this outcome so we cannot report what they said.

Other evidence
As part of our ongoing monitoring of compliance we monitor statutory notifications that providers are required to make to us. In the case of NHS trusts, the majority of these notifications are made to the National Patient Safety Agency (NPSA), who then forward the notification details to us in a regular report.

In preparation for this review we looked at the required notifications made by the trust, for all locations, since they registered with us under the Health and Social Care Act 2008 on 01 April 2010. We also looked at the trust's safeguarding adults from abuse policy and procedures which are in accordance with the local Berkshire Safeguarding Adults Policy and Procedures 2008. Both procedures included the Department of Health's 'No Secrets' definition of abuse. Using this definition we then identified incidents reported by the trust to the NPSA that fell within this definition.

Between 01 April 2010 and 07 February 2011 there were a total of 168 incidents reported to the NPSA. Of these we identified 105 incidents that described either witnessed abuse or allegations of abuse, 104 of which had been reported to NPSA

under the heading of 'Disruptive, aggressive behaviour - patient-to-patient incidents.' The types of abuse identified were: physical abuse, e.g. hitting, slapping, kicking (92 incidents) emotional/psychological abuse, e.g. threats, harassment (7 incidents) and sexual abuse, e.g. unwanted physical and sexual contact, such as caresses (5 incidents). Of these incidents, 82 were witnessed by staff and 22 were allegations of abuse reported to staff by patients.

We then looked at evidence, provided by the trust, of any incidents that had been referred to the local authority safeguarding team, as well as any incidents investigated internally using their own safeguarding adults policy and procedures. The trust was unable to provide us with their own record of incidents referred to the local safeguarding teams, sending instead information provided to the trust by five of the seven local safeguarding teams that cover the trust's locations. However, the information provided was incomplete, did not identify patient to patient incidents and was not detailed enough for us to be able to match the safeguarding referrals with any of the 104 patient to patient incidents we had identified.

The trust was able to provide us with a list of their 'internally investigated safeguarding incidents' since 01 April 2010. Of the 22 incidents on that list, we were able to match 6 to the 104 NPSA reported incidents. The narrative staff had included in their incident reports to NPSA demonstrated that the trust's safeguarding procedures had been considered for a further 3 incidents. This meant that, in total, we found evidence that 9 of the 104 incidents of patient to patient abuse had been identified by the trust as safeguarding incidents, and that staff had begun to follow the trust's and local authority safeguarding procedures, although there was no evidence provided of the outcomes of any internal safeguarding investigation.

For the remaining 95 patient to patient incidents falling within the definition of abuse, the trust provided no evidence that they had recognised or dealt with these incidents as safeguarding concerns, irrespective of whether the safeguarding investigation would be carried out internally or by the local authority safeguarding team. Evidence was provided by the trust that for 5 of these incidents at one location, their governance team had 'not determined that the incidents should be referred to the local authority safeguarding team' and that the incidents had therefore been categorised as assaults and not safeguarding incidents. This is contrary to the Department of Health's 'No Secrets' guidance and is not part of the trust's memorandum of agreement as a member of the local authority Safeguarding Adults Partnership Boards.

Although we found that the trust's safeguarding policy included references to internal safeguarding investigations and that safeguarding investigations conducted within the trust would be completed by individuals who had undergone 'Investigator Officer Training', we found no evidence of guidance or instructions to staff that safeguarding concerns (i.e. incidents or allegations of abuse) should be categorised as assaults if the decision was made not to refer the incident to the local authority safeguarding team. We also found no evidence of the trust having a policy, procedure or formal guidance to staff on when or how to carry out an internal safeguarding investigation.

We compared the 6 patient to patient incidents, that the trust had listed as investigated under their internal safeguarding procedures, with the 95 NPSA

reported incidents they had not, and found inconsistencies in how staff had applied the trust's safeguarding procedures. For example: one incident that was included in the list of incidents investigated internally involved one patient punching another on the cheek, resulting in a small bruise and cut and another where one patient punched another patient on the arm. Of the 95 NPSA reported incidents that were not included in the trust's list of internally investigated incidents, there were incidents of a similar nature, for example: one incident where one patient had punched another patient 'full in the face' and another incident where one patient was slapped around the face in an 'unprovoked attack'. The list of incidents included an 'actions taken' column. In none of these actions was there mention of an internal safeguarding investigation, only details of the action taken at the time to manage the incident. We also noted that one of the incidents on the list was an incident where a patient had assaulted a member of staff and another where a patient had been observed attempting to slap a relative. Neither of these incidents fall within the definition of abuse of a vulnerable adult, and there was no explanation as to why these incidents had been included in the list.

In November 2010 we met with the trust to discuss our concerns. At the time of that meeting we had identified 84 NPSA reported incidents that fell within the definition of abuse.

Following that meeting the trust arranged to meet with the safeguarding coordinators from some of the local authorities that cover the trust's different Berkshire locations. The meeting was held in early February 2011 with the main areas discussed being:

- agreeing and implementing a tool for determining thresholds for level of safeguarding adults responses, specifically as to whether or not safeguarding concerns would be investigated internally (level 1) under the trust's own safeguarding policy or whether the safeguarding concern would be referred to the relevant local authority safeguarding team (level 2)
- analysing the 84 incidents identified by CQC against the level 1/level 2 thresholds
- the need for regular screening of incidents to make sure that the thresholds were being applied appropriately and that individuals subject to one off attacks were being adequately protected
- the provision of clear staff guidance and leaflets so that information to staff around thresholds was backed up with posters and information
- revision of the trust's safeguarding policy to include the use of the thresholds

A number of agreements were reached at that meeting. It was agreed that the thresholds, when agreed and approved by the trust's board, would be incorporated into the trust's policy and backed up with posters and leaflets; level 1 incidents would be dealt with 'in house'; level 2 incidents would be referred to local authority safeguarding team; incidents that were level 1 would be analysed in terms of trends and repeated incidents; the trust to review and apply the thresholds to the 84 incidents, identified by CQC, to work out the proportion that should have been investigated by the trust internally and what proportion should have been referred to the local authority safeguarding teams.

As a result of our review of the evidence, we found that there was a risk that

patients were not being protected from abuse or the risk of abuse, that the trust were not responding appropriately when there was actual or alleged abuse, were not putting into practice their own or local authority safeguarding procedures and were potentially failing to protect patients from the negative effect of any behaviour by other patients. However, it is positive to note that the trust have recognised the areas they need to improve, have begun working towards achieving compliance and have told us that the draft threshold tool is already in use.

Concerns relating to the monitoring and reviewing of safeguarding incidents are addressed later in this report under outcome 16: Assessing and monitoring the quality of service provision.

Our judgement
The trust has not made suitable arrangements to ensure that patients are safeguarded against the risk of abuse, is not taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and is not responding appropriately to allegations or incidents of abuse.

Overall, we found that improvements are needed for this essential standard.

Outcome 12:
Requirements relating to 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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are minor concerns with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We did not speak with patients as part of the review of this outcome so cannot report what they said.

Other evidence
In a recent review of one of the trust's locations we found that the trust had employed staff without first obtaining all of the documents and information required by the regulations. We also found that cross checking of the obtained information and documents was not always robust. We found that this non-compliance applied to all staff employed at that location since the new regulations came into force in April 2010. Following that review the trust told us that they had amended their application form to reflect the requirement of a full employment history and that a review of all staff recruitment since the trust's registration in 01 April 2010 had begun. We were told that the trust would review their policy and procedures in relation to staff recruitment.

As part of this review we visited the trust's head office to sample staff recruitment files for all locations. We gave the trust short notice of our visit so that all the required information would be available. The visit took place on the 8th February 2011.

We sampled the files for the fifteen most recently recruited clinical staff, the staff files were chosen by us and covered all locations where staff had been employed since the new regulations came into force on 01 April 2010 and represented just over 10% of the clinical staff recruited in that time. The number of files sampled from each location was proportionate to the size of the location and the number of new staff employed.

In the files sampled we saw that many had already been reviewed by the trust as part of their recruitment review and we saw that the trust had identified and obtained any information that was missing. Of the fifteen files we sampled, eleven files contained all the required information and we saw evidence that the files had been checked for compliance against the new regulations. In two of the remaining four there were some unexplained gaps in employment and in one of those two there were discrepancies between dates and place of employment given by the applicant and dates of employment given by the referee that had not been explored. The remaining two files had all the information required of the regulations but the trust had not obtained proof of a qualification that they considered essential for a person employed in that position. We were later told that the proofs of qualification had been obtained and that the trust would ensure that all recruiting managers would be made aware of the need to be sure of consistency in the future. It was positive to note that the trust was taking action to reach compliance for staff already employed, and was taking steps to change future recruitment practices in order to achieve compliance with the regulations and this essential standard.

Our judgement

The trust does not have effective recruitment procedures to ensure that people, employed to carry on the regulated activity, are of good character and the trust does not ensure that all information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 was obtained and available in respect of people employed.

Overall, we found that improvements are 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

There are major concerns with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not speak with patients as part of the review of this outcome so cannot report what they said.

Other evidence
In a recent review of one of the trust's locations we found that the trust had not developed and put in place an effective system that enabled them to assess their compliance against the requirements of the Health and Social Care Act 2008 (HSCA 2008) and related regulations.

In preparation for this review, in February 2011, we asked the trust to provide us with any evidence of systems or alternative systems in place for the assessment and monitoring of the quality of service provision at the trust, specifically in relation to this outcome and regulation. As part of this review we looked at the information returned to us by the trust.

We were provided with a copy of the trust's 'Quality Governance Improvement Plan 2010 - 2011, October 2010 update' which included three specific supporting improvement plans that considered: patient safety; patient experience and

engagement and clinical and service effectiveness.
In that document we saw that one of the objectives the trust had set was: 'To ensure that there is a robust monitoring and reporting system that ensures that registration requirements are met for the benefit of service users and to provide assurance to the regulator (CQC).' One of the actions the trust set to achieve that objective was to: 'develop and maintain a corporate evidence portfolio and location portfolios, basing both on the CQC's Provider Compliance Assessment tool.' Another action was to undertake half and full year reviews of compliance evidence for each essential standard of quality and safety. The target date set by the trust for completion was by December 2010. Whilst the action plan seen demonstrated that the trust had a clear understanding of the need to put a system in place to monitor their compliance with the regulations, we were not provided with an update on whether or not this objective had been met or evidence that the proposed system had been developed and implemented.

Also in the recent review of one of the trust's locations we found that trust policies, which had been reviewed since their registration in 01 April 2010, had been reviewed in line with changes in other legislation but that none had been reviewed against the changes brought about by the HSCA 2008. In the trust's 'Quality Governance Improvement Plan 2010 - 2011, October 2010 update' we saw that the trust had set an objective: 'To ensure the trust's quality governance system continues to develop and remain in line with the requirements of the external environment' with one of the objectives being to 'review and update the clinical policy framework.' The action plan gave a completion date for that work of April 2011. We were not provided with an update on the progress towards achieving that objective.

In February 2011 the trust told us that, following discussion with us, the trust had: 'reviewed its 'Policy on Policies' to ensure that it was made explicit that, when writing or reviewing a policy, staff ensured that the policy had been reviewed in the specific context of the requirements set out in the Essential Standards of Quality and Safety and that that was documented.' The trust also told us that work was underway on reviewing the trust's staff recruitment and safeguarding adults policies and procedures. We were not provided with any information on work underway to review any other policies against the requirements of the HSCA 2008 and related regulations.

In the trust's 'Quality Governance Improvement Plan 2010 - 2011, October 2010 update' the trust detailed other specific actions and milestones relating to improving patient safety, including actions to: develop and implement a plan to strengthen further compliance with the hygiene code; to develop and implement a safeguarding children improvement plan and to develop and implement an action plan in response to the CQC Mental Health Act annual statement. In relation to the improving patient experience and engagement, specific actions included to: develop and re-launch the 'patient experience trackers'; develop a suite of patient experience measures and a consolidated service user feedback report and improve learning from complaints by developing and disseminating a quarterly report that draws out learning. In relation to improving clinical and service effectiveness, the specific actions included to: develop a three year clinical audit strategy and develop and

implement an annual clinical audit programme. These specific actions all had timescales that had passed, ranging from August 2010 to April 2011. The trust did not provide evidence of its monitoring of the improvement plan for implementation of the specific actions, of the result of any review of the effectiveness of actions taken or of progress towards meeting the objectives within the prescribed timescales.

Whilst the trust's 'Quality Governance Improvement Plan 2010 - 2011, October 2010 update' evidenced that the trust had plans in place working towards implementing systems that would enable them to regularly assess and monitor their compliance against the requirements of the HSCA 2008 and related regulations, the improvement plans did not evidence effective operation of systems in place for that purpose.

Concerns identified during this review in relation to safeguarding patients, specifically in relation to incidents of patient to patient abuse, are addressed under outcome 7 of this report. In order to evidence how these incidents are monitored and handled, the trust provided us with a number of documents. These included the trust's 'Quality Governance Improvement Plan 2010 - 2011, October 2010 update' with supporting evidence including: the trust's risk management report on adverse incidents from April 2010 to September 2010; a trust 'score card' covering April to June 2010; a copy of a quarterly patient safety narrative report dated October 2010 and a covering contextual response letter.

In the trust's 'Quality Governance Improvement Plan 2010 - 2011, October 2010 update' there were a number of objectives and specific actions related to improving the prevention and management of violence and aggression; improving the sexual safety of people using inpatient services; improving the reporting, management and learning from serious incident investigations and improving learning from the analysis of reported incidents. The improvement plan did not include actions related specifically to patient to patient incidents of abuse.

The supporting documents showed that the trust was monitoring reported incidents relating to a number of different areas of patient safety. The trust's risk management report on adverse incidents from April 2010 to September 2010 contained a statistical overview on accidents and incidents reported on adverse event forms. This report gave different breakdowns and overviews of the incidents by month, location of incident, severity of incident, type of service provision, and type of incident. The report included a detailed breakdown of the incidents of patient 'abuse to staff' together with a summary of actions taken by the trust relating to the handling of those incidents and the actions taken with a view to preventing or reducing recurrence. The report, while detailed, did not give an overview of incidents of patient to patient incidents of abuse. There were a number of categories for the types of incidents where patient to patient incidents could have been reported, for example: aggressive behaviour; assault by patient; threatening behaviour; inappropriate behaviour and verbal abuse by patient, but patient to patient incidents of abuse were not analysed in that report.

The remaining two supporting evidence documents did report specifically on patient

to patient incidents, the trust's 'score card' gave statistical information of the numbers of physical assaults on patients for the three months from April to June 2010, and the patient safety narrative report of October 2010 included monthly statistics on the number of physical assaults on staff and the number of physical assaults on patients from April to August 2010. That report identified a comprehensive review and update of the training programme as the key service improvement activity during 2010 - 2011. That improvement activity linked to the objective in the trust's internal plan of improving the prevention and management of violence and aggression by implementing a revised training programme. That report anticipated that 90% of inpatient staff would be trained in the revised approach by the end of the planning year. We were not provided with information relating to the progress of that target.

The trust is a member of the local Berkshire Safeguarding Adults Partnership Boards (SAPBs). The Berkshire Safeguarding Adults Policy and Procedures 2008 set out the responsibilities of each partner agency in relation to monitoring safeguarding activity within its organisation. Those responsibilities included:

- providing an annual statement to the SAPBs for its endorsement describing the internal reporting and decision-making framework in relation to any concerns that an adult may be experiencing abuse or neglect
- its achievements and operational plans for the internal implementation of safeguarding adults work
- providing monitoring information to the partnership.

Those responsibilities are also included in the trust's internal Safeguarding Adults from Abuse policy and procedures.

As part of the preparation for this review, and in order for us to assess the trust's monitoring of safeguarding concerns, we requested a copy of the trust's latest annual report to the SAPB. In response to our request, the trust told us that the annual reports were not produced as it had not been the practice of the SAPBs to request them, but rather that partner organisations were requested to provide verbal updates or specific information for inclusion in the SAPBs annual reports.
The trust did not provide us with any other evidence to demonstrate that safeguarding concerns were being monitored in any other way that met the expectations of the local SAPBs for monitoring and reporting on safeguarding concerns.

Our judgement

The trust has not developed and put in place effective systems that enable the registered person to regularly assess and monitor the quality of the services provided in carrying on of the regulated activities against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, or to identify, assess and manage risks related to the health, welfare and safety of patients and others who may be at risk from the carrying on of the regulated activities.

There is no effective system in place, at trust or location level, that enables the trust to specifically identify, monitor and analyse individual incidents of patient to patient abuse for trends or for risks to patients from incidents of patient to patient abuse that

result in, or have the potential to result in, harm to another patient.

Overall, we found that improvements are needed for this essential standard.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:

- Can be confident that important events that effect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are major concerns with outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
We did not speak with patients as part of the review of this outcome so cannot report what they said.

Other evidence
As part of our ongoing monitoring of compliance we monitor statutory notifications that providers are required to make to us without delay. In the case of NHS trusts, the majority of these notifications are made to the National Patient Safety Agency (NPSA), who then forward the notification details to us in a regular report. In October 2010, we noted that a number of notifications were being reported by the trust to the NPSA with considerable delay.

In November 2010 we met with the trust to discuss our concerns. The trust told us that they would look at their system and see what changes could be made so that they could address the time notifications were taking to reach us. The trust later told us that they had increased their frequency of forwarding notifications to NPSA from once a month to once a week. We were told that staff at the different locations notified all incidents via the trust's electronic reporting system at the time of the incident and that their governance team then check the reports before forwarding them to the NPSA.

We carried out an analysis of the reporting times for all incidents notified by the trust to the NPSA between 01 April 2010 and 17 January 2011. There were a total of 105 incidents.

Of those notifications we found:

- 13% were made between 0 and 14 days after the incident
- 18% were made between 14 and 30 days after the incident
- 44% were made between 31 and 60 days after the incident
- 11% were made between 60 and 90 days after the incident
- the remaining 14% were made more than 90 days after the incident

We analysed the incidents notified by the trust to the NPSA during the month of December 2010. There were a total of 20 incidents.

Of these notifications we found the time range for reporting was between 5 and 244 days after the incident.

- 30% were made between 0 and 14 days after the incident
- 10% were made between 14 and 30 days after the incident
- 15% were made between 31 and 60 days after the incident
- 5% were made between 60 and 90 days after the incident
- the remaining 40% were made more than 90 days after the incident

We then analysed the incidents notified by the trust to the NPSA during the month of January 2011. There were a total of 47 incidents.

Of these notifications we found the time range for reporting was between 1 and 106 days after the incident.

- 21% were made between 0 and 14 days after the incident
- 17% were made between 14 and 30 days after the incident
- 34% were made between 31 and 60 days after the incident
- 13% were made between 60 and 90 days after the incident
- the remaining 15% were made more than 90 days after the incident

The National Reporting and Learning Service (NRLS) (part of NPSA) recommends that NHS organisations should submit reported patient safety incidents regularly to the NRLS, regularly is defined by the NRLS as at least monthly.

We consider notifications, required under this outcome, as not being without delay when they are received more than 30 days after the incident. Our analyses showed us that over 50% of all notifiable incidents at the trust, reported to the NPSA and shared with us, were submitted more than 30 days after the incident occurred.

Our judgement

The trust has failed to notify the Commission (or National Patient Safety Agency), without delay, of incidents specified in regulation 18 (1) and (2)(b)(e) of the Care Quality Commission (Registration) Regulations 2009.

We are taking further action to protect the safety and welfare of people who use services.

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.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Treatment of disease, disorder or injury

Assessment or medical treatment for persons detained under the Mental Health Act 1983</td><td>Regulation 11
of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 7: Safeguarding people who use services from abuse</td></tr>
<tr><td colspan="2">How the regulation is not being met:

The trust has not made suitable arrangements to ensure that patients are safeguarded against the risk of abuse; is not taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and is not responding appropriately to incidents of abuse.

Overall, we found that improvements are needed for this essential standard.</td></tr>
<tr><td rowspan="2">Treatment of disease, disorder or injury

Assessment or medical treatment for persons detained under the Mental Health Act 1983</td><td>Regulation 21 and Schedule 3
of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 12: Requirements relating to workers</td></tr>
<tr><td colspan="2">How the regulation is not being met:

The trust does not have effective recruitment procedures to ensure that people, employed to carry on the regulated activity, are of good character and the trust does not ensure that all information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 is obtained</td></tr>
</table>

<table>
<tr><td></td><td colspan="2">and available in respect of people employed.

Overall, we found that improvements are needed for this essential standard.</td></tr>
<tr><td rowspan="2">Treatment of disease, disorder or injury

Assessment or medical treatment for persons detained under the Mental Health Act 1983</td><td>Regulation 10
of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 16: Assessing and monitoring the quality of service provision</td></tr>
<tr><td colspan="2">How the regulation is not being met:
The trust has not developed and put in place effective systems that enable the registered person to regularly assess and monitor the quality of the services provided in carrying on of the regulated activities against the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, or to identify, assess and manage risks related to the health, welfare and safety of patients and others who may be at risk from the carrying on of the regulated activities.

There is no effective system in place, at trust or location level, that enables the trust to identify, monitor and analyse individual incidents of patient to patient abuse for trends or for risks to patients from incidents of patient to patient abuse that result in, or have the potential to result in, harm to another patient.

Overall, we found that improvements are needed for this essential standard.</td></tr>
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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 this report being received.

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 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.

Information for the reader

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