East Sussex Healthcare NHS Trust  
Eastbourne District General Hospital

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<th>Region:</th>
<th>South East</th>
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| Location address: | Kings Drive  
Eastbourne  
East Sussex  
BN21 2UD |
| Type of service: | Acute services with overnight beds  
Community healthcare service  
Dental service |
| Date of Publication: | November 2012 |
| Overview of the service: | Eastbourne District General Hospital is located on the outskirts of Eastbourne town centre on one of the main thoroughfares into Eastbourne.  
The hospital provides a range of acute surgery and medicine, for all ages. |
This includes a consultant-led maternity service on site.
Our current overall judgement

Eastbourne District General Hospital 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 because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 12 - Requirements relating to workers
Outcome 14 - Supporting workers
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 20 - Notification of other incidents

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 12 October 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

The Care Quality Commission was notified by the trust of four serious untoward incidents that had occurred. We undertook a responsive review to ascertain any ongoing impact on people’s safety and to establish action taken by the trust in response to these incidents.

Five people who were using the service were spoken with and were asked for their views on their treatment, and the care provided in the maternity unit.

All feedback received was positive. People felt that they had been involved in any decisions made about their care, with options and consequences being fully explained. They were happy with all the care that they had received and felt that they had been well treated.

New mothers told us that staff were available, responded to any questions and provided support with their babies as necessary.

People told us that they had confidence in all the staff, who they said had the required skills to undertake their work effectively. This made them feel safe and that they could rely on the care and treatment that was provided to them.
What we found about the standards we reviewed and how well Eastbourne District General Hospital was meeting them

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

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

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 cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider was meeting this 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.

**Outcome 20: The service must tell us about important events that affect people’s wellbeing, health and safety**

The provider had an effective system to report incidents to the Care Quality Commission in a timely manner.

The provider was meeting this standard.

**Other information**

In a previous review, we found that action was needed for the following essential standards:

- **Outcome 09: People should be given the medicines they need when they need them, and in a safe way**
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 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
Five people who were using the service were spoken with. This included two new mothers, their partners and one lady who had been admitted for antenatal care.

All feedback received was positive about the care and support provided. People felt that they had been involved in any decisions made about their care, with options and consequences fully explained. One couple described how an emergency decision had been explained and followed through effectively. "We have been constantly informed and involved throughout, it has been fantastic."

New mothers told us that staff were available, responded to any questions and provided support with feeding as necessary. One mother told us that "Staff were available for support and would always respond to the bell, but were not always seen around checking regularly."

Other evidence
Five sets of records were looked at and these demonstrated that records were well maintained and chronological. They recorded discussions with people using the service and how care and any medical interventions were to be progressed. The notes held information about the services available, choice of delivery, programme of antenatal care and what tests meant as well as information around antenatal scans. There was guidance for staff and details of how care was risk assessed throughout the antenatal, delivery and postnatal period. People who used the service held their own notes during the antenatal period. Notes were kept in the rooms during the delivery period.
Notes contained a sheet that listed the names of all the staff and professionals involved in the person's care. This included their designation, full name and signature so that people knew who to contact or refer to, if there were any issues they wished to discuss.

We saw daily charts that confirmed observational checks were completed in order to monitor people's health and comfort. Summary care plans were recorded and identified key care needs for each person admitted to the unit. Care and treatment was planned and delivered in a way that ensured people's safety and welfare.

The records allowed for the multidisciplinary team to record all information in one area which promoted communication between all team members. Records written retrospectively when emergency treatment was required were well documented, with a full history provided as soon as possible after the emergency. There were notices around the unit reminding staff of the importance of accurate record keeping.

All staff spoken with told us that they provided a good level of care. There was an acknowledgement that the maternity unit had been very busy over the last two months, and that this had impacted on staff time available for mothers following delivery. Staff told us that they would like to spend more time with mothers and new babies but confirmed that this had not affected people's safety.

We were shown that there were clear guidelines in place for assessing the risk to people using the maternity unit. The associated protocols demonstrated how these were escalated to senior management within the hospital for a decision on diverting people to other maternity units.

Staff told us that the divert systems worked well and that this allowed them to manage any presenting risk proactively. Although alternatives to the closure of the delivery suite were always considered before a divert was agreed, it was an option that the senior management used, if required, in the interest of people's safety. Two senior midwives gave us examples when they had discussed the possible use of divert with senior management. They felt that they had been listened to and that the risk had been responded to appropriately.

There were additional protocols that clearly demonstrated when a senior clinician should be called and when a consultant obstetrician should attend any deliveries on the labour ward. We saw reminders in a number of places on the delivery suite in relation to when a consultant was to be called. A schedule displayed in the delivery suite confirmed the daily obstetric cover was provided. Staff spoken with confirmed that there was always a consultant obstetrician available to them if required. Midwives said that they felt comfortable and called the consultant at any point if they felt middle grade or training grade doctors needed support.

We saw that there were clear documented pathways for people who had any medical condition that may affect their pregnancy. This contained guidance about what other professionals should be involved in care for specific conditions for all stages of pregnancy. This was to ensure a multi-disciplinary approach to care was in place and provided the optimum care and ensured people's safety.

Observation confirmed that staff were available to help new mothers with feeding and to check on their health following delivery. There was evidence that specialist advice was
sourced as necessary. An example of this was the specialist nurse for babies with a cleft palate attending the unit on the day of the inspection visit.

Staff told us that there was a daily hand over meeting that included the duty consultant obstetrician, middle grade and trainee medical staff, obstetric anaesthetist (if available) the midwife in charge of the unit and other available members of staff. This allowed for a full handover and the sharing of important information. Staff said that this was an effective system for communication and discussion and over the last year had been well attended.

In addition, the medical staff used a handover sheet to pass information on between shifts. We were shown an example of this. We saw that the staff grade obstetrician had ensured follow up appointments had been made for one person, and recorded a detailed review of another. This sheet was updated or renewed at each change of shift for the medical staff.

We were shown a recently introduced document that recorded any incidents that had occurred in the unit and this was discussed during the handover meeting to ensure that all incidents had a multi-disciplinary overview within 24 hours of occurring.

Management staff spoken with said that the introduction of the incident sheets and the recording of discussions about incidents at an early stage ensured that concerns were dealt with promptly. Immediate actions were taken to protect the person involved and reduce any risks to other people. In addition, a full investigation and root cause analysis would always take place at a later date as per the trust’s serious incident reporting policy.

**Our judgement**

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

The provider was meeting this 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

The provider is compliant with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
People spoken with told us that they had confidence in the staff working on the maternity unit and believed that they had the required skills to undertake their work effectively.

One lady told us "Staff are knowledgeable and attentive I am very impressed with the care and staff" another told us "Staff are skilled and helpful."

Other evidence
Discussion with staff confirmed that the staff team was stable and there was not a large staff turnover. Managers informed us that they had no long term vacancies and 'everything' was recruited to. However, staff sickness and maternity leave had led to staff shortages, equating to approximately a 15% reduction in whole time equivalents in the maternity workforce until the end of the year.

Discussion with managers evidenced that they had spent time considering ways of addressing the present staffing issues. The midwifery staffing (regarding high numbers going on maternity leave and sickness) had been on the risk register since August 2012. We saw that processes had been developed to mitigate the risk. There had been discussions with staff and external agencies and the trust had worked closely with their commissioners and the Strategic Health Authority. Some of the initiatives included the redeployment of specialist midwives. For example, the additional support midwife who provided guidance to young and vulnerable mothers and the midwifery feeding specialist. The unit had risk assessed this approach and they have back-filled the
additional support role with extra support workers. The midwifery feeding specialist was based on the postnatal ward, so was still available and provided support with feeding.

There had been increased contracted hours for part-time staff. Full-time staff that worked extra hours were paid to the band and point on the incremental scale that they were employed at rather than being asked to cover time on bank payment rates. When talking to staff, they said that they found this much fairer and liked to be given the opportunity to work extra hours. The unit had commenced recruiting to a bank for midwives and maternity support workers which provided more consistent staffing. In addition, agency staff were used to cover some shifts. Student midwives were offered three to six month contracts on qualification to consolidate their learning and also to increase staffing levels. Band 5 nursing staff from elsewhere in the clinical unit were being redeployed to help with operative deliveries and to support women in the postoperative period, thus releasing midwives to carry out their more specialised roles.

We saw a schedule for staffing that was being used to clarify what staff were required, and to book agency staff. These were planned a month in advance and reviewed regularly.

The duty rota seen confirmed that planned staffing arrangements provided a suitable skill mix throughout the maternity unit. We were told that the optimum safe level of six midwives, one of which was a band 7 or competent to this level, was mainly maintained. This meant that midwives were moved from management roles if required or a community midwife was re-allocated. The duty rota confirmed that this assertion was followed through.

If staffing levels were thought to be unsafe due to number of staff, level of staff competence, or the identified needs of people on the unit, guidelines to escalate this risk were in place. Staff were familiar with these and used them if required.

We were told that there was a contract with two agencies that provided suitable midwives to cover identified shortfalls. Senior management told us that this contract assured that all the required safety checks had been completed on these staff and that they were competent and qualified midwives. In addition, their curriculum vitae was vetted by the managers and feedback from permanent staff was used when considering their use.

We were told by management that agency staff came into the unit for orientation prior to starting any shifts. If this was not possible the rota ensured that there was always a senior member of the permanent staff available to oversee them, especially for the first few shifts. We were told that agency staff competence was reviewed during daily practice and that they were always working with a senior midwife. The practice of two agency staff had been brought into question and the unit had taken up these concerns. Disciplinary action had been followed through and these incidents had been reported appropriately to the relevant professional bodies.

The provider may find it useful to note that, although we were told that agency staff received an induction to the premises and the hospital procedures, there was no documentary evidence that this was undertaken. However, one of the agency staff spoken to said that they knew where everything was and felt very supported by everyone on the unit. It was raised that the agency staff did not have access to the
computer system which slowed processes down and necessitated further support from other staff.

Staff told us that four midwives had recently been recruited and were to start work within the next two months. Discussion with staff confirmed these staff had been recruited to a level of competence to support the team appropriately. In addition, a senior midwife was due to start work in the unit on 12 November 2012 to provide support for long term strategic planning.

In relation to medical cover, the lead clinician told us that there were 11 consultant obstetricians in place to cover both units. He said that this included a long term locum. We looked at the obstetric rotas and saw that consultants provided a minimum of 40 dedicated labour ward hours as per national guidance. Consultants cover all elective caesarean section lists. Recently there had been agreement and guidance produced for staff to reinforce the need for consultant cover for all operative deliveries unless the middle grade doctor held the certified completion of training certificate. In addition there was 24 hour access to consultants. The lead clinician stated that he felt that the present number of consultants was safe.

In relation to other grades, there has been national recognition that the availability of middle and junior grade doctors was decreasing. The unit had been part of a Sussex wide group considering safe numbers and ways to recruit to this area. Locums have been used to ensure that all medical shifts were appropriately covered. We were told that the locums used were usually well known to the unit, "about 95% of the locums we use are well known to us". If they were not known they were required to send their curriculum vitae well in advance and competencies would have been checked prior to their first shift. New locums were requested to work a day time shift and the consultant assessed them and provided an induction to the unit and policies. If they were unable to do this they were expected to come in early and speak to the consultant and worked with a registrar. The consultant on call determined the threshold for the locum to call them in. Only doctors deemed competent locally, by being observed and assessed, performed operative deliveries.

**Our judgement**
People were cared for, or supported by, suitably qualified, skilled and experienced staff.

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

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What people who use the service experienced and told us
All feedback from people using the service indicated that they felt safe and that their health and welfare needs were being met by a competent workforce. One lady said "I have had a good experience here, I have seen the consultant and everyone that I need to see."

Other evidence
We spoke with a variety of staff who were working on the day of the inspection. This included three senior midwives, one agency midwife, one junior and one student midwife. In addition we spoke to medical staff including the clinical lead for obstetrics for the trust.

Staff spoken with and observed were well motivated and committed to providing safe, appropriate care and treatment. Staff told us about the good team spirit enjoyed by staff. Two junior staff said that they felt able to ask any question and did not feel "silly" or "intimidated". They felt able to and approached anyone including the obstetrician.

All staff told us that they felt well supported by the management and medical team. One midwife was taking on a senior role in the unit and although this was not a role that she wanted long-term they felt appropriately supported and were enjoying the increased responsibility.

Midwives spoken with told us that they received annual appraisal and professional supervision.
Medical staff stated that they had regular supervision and that their competencies were reviewed with their consultant.

Midwifery staff and maternity support workers explained the system in place that ensured all staff attended mandatory training each year. This was co-ordinated centrally and provided three days for staff to attend over the year. A schedule for this training was seen and gave staff the opportunity to attend days that suited their own schedules. Records of attendance were kept centrally and staff were followed up if they did not attend. Mandatory training included a number of topics including infection control, fire, moving and handling and safeguarding for adults and children.

Staff told us that there was an opportunity for personal development and this was discussed and recorded when personal objectives were set each year. We were given an example from a maternity support worker who was about to attend training around ‘Difficult conversations’. She said that the training was there and staff had to put themselves forward.

Medical staff had attended mandatory training and updates as per the trust's policy. They were supported to attend study days of interest only if their mandatory training was up to date. This was monitored centrally. Medical staff in training received the mandatory training as part of their induction to the trust and unit. They had specific training requirements and their competencies were assessed as per national guidelines.

Midwifery staff, students and maternity support workers said that they felt well supported and listened to. The lead consultant said that although there were some frustrations, for example the fact that the maternity staffing had been on the trust risk register for some time. The medical staffing had initially been raised in April 2010, however, there had since been an increase in the employment of substantive consultants. In addition, this was now regularly reviewed at governance meetings at all levels throughout the trust, and the employment of a long term locum had reduced the risk rating. Midwifery staffing had been raised and placed on the register in August 2012 and agreed initiatives had been signed off to mitigate this in the short term and long term solutions were being explored. The trust had agreed the employment of a senior experienced midwife who commences on the 12 November 2012 to support the unit with long term maternity workforce planning. The lead clinician and head of midwifery said they felt well supported and had direct access to the chief executive if they needed to discuss things. The lead clinician also said he was aware that there was a Sussex wide review of medical staffing for maternity.

**Our judgement**
People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

The provider was meeting this 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
We spoke to people using the service but their feedback did not relate to this standard.

Other evidence
People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. There were a number of meetings that people participated in to raise concerns or share ideas. For example, the Maternity Services Liaison Committee (MSLC) which covers all the maternity services for East Sussex Healthcare NHS Trust. The Women's Focus Group (WFG) which was site based and open to all users of the service was attended by staff as well. There was information in the antenatal records as to how people could become involved in this. The WFG considered all issues relating to maternity services and had input into any leaflet developments, changes to services and practice developments. There was also a section where the learning from incidents and complaints was discussed so that people who used the service had a say in how these were finalised. The Labour Ward Forum (LWF) had lay representation, midwifery, medical, paediatric and anaesthetic staff. This ensured that there was multi-disciplinary participation in the topics discussed and that changes considered the views of people who used the service as well as that of the professionals involved in their care.

People spoken with said that they felt involved in all decisions about their care and had ample opportunities to clarify anything. There were feedback forms available to people on the unit.
There were regular staff meetings where staff had the opportunity to raise concerns or influence changes in practice. We saw evidence of regular supervision for midwifery staff and support for maternity support workers. Medical staff had regular supervision from consultants. Staff said that they were happy to raise issues and felt that they were listened to.

There was a clinical governance framework in place. We were shown a table that demonstrated that the maternity department was part of an integrated division which consisted of four clinical units. These comprised of children and young people, therapies, clinical support and women and reproductive health. There was a clinical governance lead and clinical governance manager for the division, each of the units had a governance lead and the Head of Midwifery was the nominated governance lead for the women and reproductive health unit.

There were regular risk and quality, and business unit meetings and we saw minutes from the unit business meetings which demonstrated that there was discussion about staffing and agency staff used. All relevant risk issues were discussed and the minutes were fed up to the board through the governance structure. We saw copies of the maternity dashboard and saw how issues and concerns were appropriately escalated and actions put in place to mitigate the recognised risks.

Discussion with the chief executive demonstrated that he was aware of the recent incidents in the maternity unit and had reported his concerns to the commissioners and the Strategic Health Authority (SHA). He stated that he felt that the unit had been well supported. We saw minutes from weekly meetings with the SHA and Primary Care Trust (PCT) that demonstrated that the trust was working closely with them to provide a safe service.

There was evidence that learning from incidents / investigations had taken place and appropriate changes were implemented. We saw evidence that as soon as the organisation recognised that there may have been a concern about medical supervision they had acted appropriately and reminded all staff of the need to use the escalation process effectively. They had also clarified the process to ensure that consultant attendance was required on the labour ward for all operative deliveries. In addition the unit and trust had reviewed the process for assessing incidents. They now form part of a daily handover meeting which ensured rapid analysis, trending and reporting thorough the appropriate channels. There was recognition that the previous process of separate midwifery and then obstetric review delayed the process.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. We saw that there were detailed guidance and protocols for escalation in place. This ensured that the appropriate level of staff were available and provided safe care to people who used the service.

Regular audits were carried out and action plans put in place. For example, record audits, caesarean section rates, time from decision to caesarean, operative delivery rates and admissions of neonates to the special care baby unit.

All records for emergency caesarean sections were routinely reviewed by the lead clinician and obstetric team. These were then discussed at the midwifery departmental meetings to share any lessons learnt.
As a result of the recognised midwifery staff shortages due to maternity leave, we saw that there was an action plan in place which was reviewed weekly at clinical unit and divisional management level. A number of actions and processes had been developed as a result of the Birth Rate Plus review. For example, a maternity triage system to streamline activity; a restructure of midwifery management to release clinical midwifery resources; a replacement of midwifery guided tours with a virtual DVD tour. Specialist midwives had been redeployed to provide support within the core clinical team. There was agency approval in place to ensure that minimum safe staffing levels were always met. There had been active recruitment for the bank to increase the availability of midwives and maternity support workers. The trust had looked at ways of providing administrative support to release midwifery support workers to cover some of the care and to release midwifery time to where it was most needed. In addition, the unit was working towards releasing midwifery resources from theatre activity as recommended in national guidance. Following consultation and advice from the SHA and PCT, the trust had funded a post for a senior experienced midwife to support the Head of Midwifery in developing long term strategic solutions.

In relation to the issues around medical staffing, the trust had employed a long term locum to ensure 11 consultants were in place to cover the rota. There was an externally led review last year which involved specific consultation with the Royal College of Obstetricians and Gynaecology (RCOG). The trust has had SHA medical advisor opinion and he checked with the RCOG directly regarding the actions that had taken place and the implementation plan for the unit. The RCOG advises on standards of care and together with the Deanery considers training requirements for medical staff. We saw that medical rotas were reviewed on a weekly basis and that there were competency documents for locum medical staff in place. Guidance for employing locums for obstetric cover had been agreed across the trust and was in place to ensure that there was always adequate appropriate medical staffing. A specific 'task and finish' group was to be established to ensure ongoing review of the service.

The processes in place for dealing with midwifery and medical staffing were fairly recent and the SHA, PCT and the Commission will monitor the long term sustainability of the trust's actions.

The provider took account of complaints, incidents and comments to improve the service. There was ongoing feedback to all staff involved in any incidents or complaints and information was shared within teaching sessions, training updates and newsletters to ensure that the lessons learned were shared across the organisation.

There was evidence of people's satisfaction with the care provided by the unit. We saw thank you letters, card and a bunch of flowers for staff displayed on the unit.

All staff spoken to were aware of the whistleblowing procedure, complaints process and incident reporting policy.

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.
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 affect 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

The provider is compliant with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
We spoke to people using the service but their feedback did not relate to this standard.

Other evidence
We spoke to the chief executive, head of nursing, head of midwifery and clinical services manager about the process for reporting incidents to the Care Quality Commission (CQC). They accepted that there had been a recent delay in the reporting of some incidents. This had been due to the original maternity unit process of having separate midwifery and obstetric reviews and this had been compounded by issues with the National Reporting and Learning System (NRLS) that replaced the National Patient Safety Agency (NPSA) reporting system.

In relation to a specific incident that occurred on the 6 September 2012, this was reported as a serious incident on STEIS (part of the reporting system for NHS organisations) at 4:44pm on 7 September 2012. However, there was a delay in reporting this through the NRLS system via the trust's computerised system (Datix) due to the initial procedures for review of incidents. We saw that actions had been put in place to ensure appropriate escalation and reporting in the future.

Following the delay in the reporting of this incident, the divisional clinical governance team had been made aware of the process for reporting category 5 incidents via the patient safety team within the correct timescales. In addition, the patient safety team had implemented a process to escalate any failure of the division to supply a Datix form so that the appropriate Datix entry could be made in a timely manner.

The trust was aware of the process to follow and we saw that they had guidance about
reporting in place which had been discussed at relevant meetings. They had systems in place to report relevant incidents via the NRLS which met this requirement. They were also aware that incidents had to be submitted within the relevant timescale and include all the information required. The improved process at unit level, and follow up from the patient safety team had been developed to support this process of more contemporaneous reporting.

**Our judgement**
The provider had an effective system to report incidents to the Care Quality Commission in a timely manner.

The provider was meeting this standard.
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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# Care Quality Commission

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<td>Telephone</td>
<td>03000 616161</td>
</tr>
<tr>
<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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<tr>
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