Basildon and Thurrock University Hospitals NHS Foundation Trust
Basildon University Hospital

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<th>Region:</th>
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<tr>
<td>Location address:</td>
<td>Nethermayne Basildon</td>
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<td>Essex SS16 5NL</td>
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<tr>
<td>Type of service:</td>
<td>Acute services with overnight beds</td>
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<td>Date of Publication:</td>
<td>March 2012</td>
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<td>Overview of the service:</td>
<td>Basildon Hospital was one of the first 10 NHS Foundation Trusts in the country and is an associate teaching hospital. The trust provides an extensive range of acute medical services at Basildon University Hospital and Orsett Hospital serving a population of 310,000. The Essex Cardiothoracic Centre is based at Basildon University Hospital. The Centre</td>
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<td>provides specialist diagnosis for people with cardiovascular (heart) and respiratory (lung) diseases.</td>
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Our current overall judgement

Basildon University Hospital was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

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

Outcome 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 11 January 2012, checked the provider’s records, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

The overall feedback from people in the Accident & Emergency (A&E) department was positive. Whilst some had been waiting a couple of hours to be seen, they recognised the need of staff to prioritise the more urgent cases. They told us that staff were professional and caring, although information about what was happening and how long they may have to wait was not always good.

Other comments people made to us included that the department was clean, the waiting area could be larger, vending machines should be made available, information provision could be better and the seating could be more comfortable.

What we found about the standards we reviewed and how well Basildon University Hospital was meeting them

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

The trust continues to face challenges associated with the staff levels and skill mix in A&E during busy periods. However, whilst this affects waiting times it did not compromise the health and wellbeing of higher dependency patients. The hospital has demonstrated they are taking actions to address these shortfalls, although it is too early to be fully assured that there are adequate numbers of suitably qualified staff in place at all times. CQC will continue to monitor this with the trust.
**Actions we have asked the service to take**

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

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

**Other information**

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

- **Outcome 07**: People should be protected from abuse and staff should respect their human rights
- **Outcome 10**: People should be cared for in safe and accessible surroundings that support their health and welfare

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

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

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 13:
Staffing

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
During our inspection of the accident and emergency (A&E) department at Basildon Hospital we spent a lot of time talking with people who were using the service as well as their family and friends accompanying them to the department. We asked them about their experiences of using the department, the length of time they had waited and the attention they received from staff. Where it was appropriate, we talked with people who had been seen by medical staff and were occupying bays whilst a bed was found for them on the wards.

The overall feedback from people was positive. Whilst some had been waiting a couple of hours to be seen, they recognised the need of staff to prioritise the more urgent cases. They told us that staff were professional and caring, although information about what was happening and how long they may have to wait was not always good.

One person waiting in the paediatric area told us they had had to wait for about half an hour for their child to see the nurse for triage. They said that when they had attended with their child during the day there had been few people waiting to be seen, and on that occasion they had been seen and were home promptly. They said that they had found the staff to be 'lovely' and the doctor 'amazing'. They said they did not have any concerns about the service and were pleased that there was a paediatric service within the department.

Another parent we spoke with said that they had had to wait about two hours from being seen by the triage nurse to being seen by the doctor. When we checked the
records they had been waiting for just under an hour and a half. They said that they thought they had been waiting in order for the doctor to assess the effects of the medication given to their child by the triage nurse. When we spoke with staff they said this was not the case; it was as a result of the numbers of people waiting to be seen.

An adult patient we spoke with said they had waited about 30 to 45 minutes to be seen by the triage nurse. When we spoke with them they had been in the department for almost two and a half hours. They told us that they expected to wait as they did not consider that they were a medical emergency.

Another person, attending with their relative, said they had been waiting to be seen by the triage nurse for about 45 minutes. They were unaware there was any information available as to anticipated waiting times. On our arrival the information in reception advised the waiting time was an hour and a half. It was unclear though if this was the time to wait before seeing the triage nurse or the doctor. It was also unclear if this applied to both adults and children.

We spoke with the relative of another person who told us that they could not ‘fault the treatment’ given to their relative, and that their relative had had a lot of tests.

Other comments people made to us included that the department was clean, the waiting area could be larger, vending machines should be made available, information provision could be better and the seating could be more comfortable.

**Other evidence**
We carried out this follow up inspection and gathered additional evidence as a result of our findings of our last planned inspection in November 2011. We looked at whether the provider had taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed in the A&E department at Basildon Hospital to support people requiring emergency diagnostic and treatment services, especially out of hours.

On our arrival at 7pm the waiting and treatment areas were busy and remained so for the majority of our inspection which continued until 1am. We looked at the nursing rotas for the last four weeks and saw that the numbers of qualified clinical staff including emergency technicians on a night shift could vary from 14 each night down to 12 with no explained reason for the inconsistency. We saw from the clinical rota that a sister was off sick for the night shift of our inspection. On further scrutiny of the rota, we found there were nine qualified nurses on duty of the night of our inspection. We saw that for all the other shifts throughout the month they had at least ten qualified nurses on each night shift. We were informed that a decision had been made by the matron that a replacement nurse was not required as there were adequate numbers of qualified staff and emergency technicians on duty. When we questioned this further, we were told that the decision was also made as there was nobody waiting for a bed on a ward or back log of people waiting to be seen.

We asked several clinical staff why the shift was not covered and were told they did not know why. Some staff said it often happens that short notice sick leave was not covered for nursing staff, although the doctor shifts were usually covered by locums. The vast majority of clinical staff we spoke with told us that they were very busy most of the time and regularly short of staff, especially in the evenings and over night, which is
why triage and waiting times to see a doctor could be prolonged for some people who were judged to be of lower risk.

We looked at the numbers of A&E attendees from 19 December 2011 and up to 11 January 2012. On the 11 January 2012 there were 228 attendees supported by nine qualified nursing staff plus three technicians. On 10 January 2012 there were 229 attendees supported by ten qualified nursing staff and three technicians. There were numerous other examples of similar workloads with varying numbers of staff, such as on 04 January 2012, 231 attendees supported by ten qualified nursing staff and four emergency technicians. Based on this information and feedback from staff and people we spoke with, we would have expected the vacant night shift to be covered because of the potential risk to people if there were a delay in clinical decision making.

We looked at the shift reports from 19 December 2011 through to 11 January 2012 which showed several breaches of the four hour waiting times: where people had been in the department for more than four hours. We saw that these had been escalated to the unit manager by staff. On one occasion records showed over twenty breaches in the four hour wait in a twenty four hour period. The picture created by the contents of the shift reports we looked at supported what staff told us and what we saw during our inspection.

Waiting time pressure on staff could have a negative impact upon the level of monitoring for less urgent cases or patients waiting transfer to the ward. We could see from the shift reports, that staff were recording and escalating concerns. People and staff we spoke with throughout the evening confirmed that the recommended waiting times, which the trust has set, and as also recommended by the College of Emergency Medicine, of fifteen minutes for a nurse to see and assess a person and sixty minutes for a doctor to make a clinical decision on what treatment or action is required were not always being met. For example, we found that one patient was seen by triage 41 minutes after arrival, and at the time of our review they had not seen a doctor; this was two hours after their arrival. Other patients we reviewed had similar delays. Some people told us it was stressful waiting for long periods of time without an explanation and staff also expressed frustration that once they had a backlog of patients, they could spend several hours trying to catch up, resulting in a lack of rest breaks.

We looked at children's services in the department. At the time of our inspection there were two paediatric nurses on duty all day up to ten or eleven o clock at night. The adult trained staff then took over. They all had level three safe guarding training and paediatric life support training including recognising the signs of the deteriorating child. Staff rostered to work with adults who we spoke with were confident about looking after children, but felt the time for clinical decision making could at times be delayed due to the lack of senior and appropriately qualified doctors in the department at night. One staff member told us "They put in a paediatric area in response to concerns raised by the Care Quality Commission, but did not provide additional resources to run it effectively." Staff we spoke with told us that the worse periods tended to be when the consultant left in the evening. The pressure on the remaining middle grade doctors could be excessive at times.

The hospital provided us with up to date waiting times for seeing a clinical decision maker which showed since 19 December 2011 the trust had achieved the aim of sixty minute waiting time three days out of 24. People were regularly waiting more than 80
minutes and at times, especially over the Xmas period, were waiting up to 140 minutes. We spoke with doctors and clinical staff about the waiting times and it was clear from the waiting times and feedback from staff that there were not enough permanent middle grade doctors at night. In addition there were too many locums to be fully assured of timely adequate clinical decision making practices at all times.

Our observations and conversations with people indicated that staffing levels did not always meet the needs of people using the department when there were high demands and this could impact on the level of monitoring for less urgent cases or patients awaiting transfer to an appropriate ward. Staff we spoke with were very clear that higher risk patients were always prioritised and treated quickly and that the levels of staff, whilst short at times, did not compromise the health and wellbeing of higher dependency patients. One person we reviewed was seen by the triage nurse within three minutes of arrival and seen by the doctor within 29 minutes of arrival. We were told that this person was called to see the triage nurse promptly due to their health care need and known history.

We were told by staff that the hospital had recently recruited three more emergency nurse practitioners and that new initiatives such as basing a middle grade doctor in the minor injuries area to streamline some of the waiting times were being implemented. We were told by one member of staff that they considered the skill mix of staffing in A&E to be good as experienced staff who had been absent, for example, on maternity leave were now returning. One staff member we asked said that they felt the nurses in A&E were adequately trained; and that there may only be one or two nurses on a shift who were not able to carry out the full range of tasks in the department. In total there were eight emergency nurse practitioners. The trust had recently advertised for more emergency nurse practitioners and had 35 applicants for three vacant posts. Once recruitment has been completed the trust planned to have one emergency nurse practitioner on each night shift.

Most of the staff we spoke with reflected that not enough was being done, such as incentives, to fill the vacancies and additional job roles to support the growing demands of the accident and emergency department. There were concerns by the staff, that when the new A&E building is fully open in April 2012 there will not be adequate resources available to staff it appropriately throughout the 24 hour period. Whilst there was a business plan to address this, staff told us there had been a lack of timely actions for additional recruitment and although some initiatives were now being introduced to attempt to manage the work streams more efficiently, staff felt it was reactive and another attempt to 'plug a hole', when the main concern was a lack of suitable qualified staff.

At our inspection in November 2011, we saw a business plan, which showed that the trust's A&E department had less consultant and middle grade medical A&E staff in post compared to other trusts of a similar size and population. The forecast for 2011 for Basildon Hospital was for 90,000 attendances at A&E in a year, which was higher than similar sized trust's in Essex. The board of directors approved the recruitment schedule outlined in the business plan to address this gap on 29 November 2011. The Care Quality Commission consulted an external A&E expert clinical adviser who noted that it was recognised that there were national difficulties recruiting medical A&E staff and that the trusts needed to look at initiatives to attract medical staff and consider new ways of working such as the use of general practitioners in the units to manage some of the care pathways and developing the Emergency Nurse Practitioner role. We were
informed by the trust that this was being undertaken.

Following our inspection in January 2012, we have asked for additional information and progress updates regarding recruitment for the A&E department. The update provided on 29 February 2012 showed us that the trust had shortlisted seven middle grade doctors for interview on 15 March 2012 and were hopeful that the four vacancies will be filled, removing the need for locums.

Two additional locum consultants have been appointed. One will commence mid March and one at the end of the month. The substantive consultant posts will be re-advertised in April 2012 with interviews in May, which is when the new group of trainees will obtain their qualifications and be available for appointment. We were told that until any appointees are able to join the trust, the locum consultants will remain in post.

The trust had seven Emergency Nurse Practitioners vacancies (new posts) in November 2012. They have now recruited to all of these with three in post now and the remaining four due to take up positions between now and the end of April. This completes this rota.

The A&E department now have eight paediatric nurses in post, with one vacancy. This post has been advertised and shortlisted and interviews will be held before the end of March 2012. This will ensure that there will be at least one children's nurse on every shift (two on day shift) supported by a specially trained emergency technician. The Department will continue to use adult emergency nurses within the children's department to maintain competence in managing children. The Royal College of Nursing has produced competencies for adult emergency nursing in the management of sick children and the department was using these to ensure on-going competence in this area. They had appointed a full time Clinical Lead – Nursing (band 7 Paediatric trained Senior Sister) to provide clinical and professional leadership to the team and 0.25 WTE Clinical Facilitator to oversee the training and education of the staff working with children. The new Children's Emergency Department is now fully open, 24 hours a day, providing segregated services for children and adolescents.

The Care Quality Commission will continue to monitor the success of the recruitment schedule for the A&E department with the trusts senior management team.

Our judgement
The trust continues to face challenges associated with the staff levels and skill mix in A&E during busy periods. However, whilst this affects waiting times it did not compromise the health and wellbeing of higher dependency patients. The hospital has demonstrated they are taking actions to address these shortfalls, although it is too early to be fully assured that there are adequate numbers of suitably qualified staff in place at all times. CQC will continue to monitor this with the trust.
## 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.

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<th>Regulated activity</th>
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<th>Outcome</th>
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<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 13: Staffing</td>
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<td><strong>How the regulation is not being met:</strong></td>
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<td>Surgical procedures</td>
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<td>Maternity and midwifery services</td>
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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 the date that the final review of compliance report is sent to them.

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

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

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

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

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

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

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

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

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

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

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<th>Document purpose</th>
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<td>Author</td>
<td>Care Quality Commission</td>
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<td>Audience</td>
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### Care Quality Commission

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| Postal address                     | Care Quality Commission  
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