### Review of compliance

**Basildon and Thurrock University Hospitals NHS Foundation Trust**  
**Basildon University Hospital**

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| **Location address:** | Nethermayne  
Basildon  
Essex  
SS16 5NL |
| **Type of service:** | Acute services with overnight beds |
| **Date of Publication:** | September 2012 |
| **Overview of the service:** | Basildon Hospital were one of the first 10 NHS Foundation Trusts in the country and are an associate teaching hospital. Providing an extensive range of acute medical services at Basildon University Hospital and Orsett Hospital, they primarily serve the 310,000 population of Basildon and Thurrock in South West Essex, plus some residents |
of the neighbouring districts of Brentwood (for whom they are the main provider of cardiology services) and Castle Point.
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 16 - Assessing and monitoring the quality of service provision

**How we carried out this review**

We reviewed all the information we hold about this provider, carried out a visit on 4 September 2012, checked the provider's records, talked to staff, reviewed information from stakeholders and talked to people who use services.

**What people told us**

We did not speak to people regarding this standard as this was a review of a warning notice around incident reporting, quality monitoring and assessment practices.

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

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 was meeting the standard.

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

**Other information**

In a previous review, we found that action was 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

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

• Outcome 17: People should have their complaints listened to and acted on properly

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 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 did not speak to people regarding this standard as this was a review of a warning notice around incident reporting and assessment practices.

Other evidence
At our last inspection to the hospital in June and July 2012 we found that the hospital did not have robust quality checking systems in place to manage risks and assure the health, welfare and safety of people who receive care. As a result of the provider failing to comply with relevant requirements, a warning notice was served by the Care Quality Commission on 05 July 2012. The provider was required to become compliant by 30 August 2012.

When we visited Basildon Hospital in June and July 2012, we identified significant shortfalls in the management of incidents that resulted in, or had the potential to result in harm to people. We found concerns about how the provider was making changes to improve the treatment and care provided to patients. We also found that there was not an effective system operating to allow responsible staff to regularly assess and monitor the quality of the services it provided, in relation to patients going into rapid deterioration. This meant that risks in relation to these matters were not being identified or managed in a sustained or effective way.

At this inspection carried out on 4 September 2012, we visited five clinical areas and spoke with 20 staff, which included nurses, health care assistants, doctors, non executive directors and radiographers. We looked at the work that had been completed...
since the trust was issued with the warning notice in July 2012, in particular regarding the handling of serious incidents (SIs) and patient safety.

We followed through the revised quality checking process for serious incident reporting and patient safety practices from the board of directors through the clinical governance teams, patient safety committees and through to the clinical directorates providing care for patients. We spoke to staff at all levels of the organisation and looked at minutes of meetings and results of audits that had been carried out since we issued the warning notice. We found that there was now a clear communication channel to and from clinical directorates to the board of directors regarding the management of risks and assurance regarding the health, welfare and safety of people who receive care. Staff were clear on their role in patient safety and levels of accountability for ensuring practice changes were implemented to improve patient care. They were able to give examples of recent practice changes resulting from serious incidents, such as new rapid assessment practices in A&E for children and improved handover information regarding pressure sores.

The trust had introduced a number of initiatives which were being embedded as routine work on the wards we visited. Since we raised concerns at the last inspection, new revised policies had been agreed that covered serious incidents (SIs), incidents and investigations. Lessons learnt were available on the trust's intranet for staff reference. Our discussions with staff from clinical areas up to directors who sit on the hospital's board showed us that they were knowledgeable about the changes, the need for the changes and the revised procedure. This was particularly clear in respect of the increase in the recording and reporting of incidents of pressure sores.

Patient safety awareness amongst staff had improved significantly since our last inspection. The trust was in the process of introducing ‘Patient Safety Boards’ (PSBs) onto each clinical area, which contained information about serious incidents and learning from each incident. The boards were seen to be in place in all of the areas we visited and staff explained to us what they were and why they were there. Patient safety folders accompanied the PSB and contained helpful information and guides for staff about effective action planning, and better investigation practices. We saw eye catching posters displayed for all staff on practice changes resulting from incidents or audits, such as comfort round charts to include the checking and removal of support stockings to prevent ulcers forming. We were informed that this programme will be ongoing with the information being refreshed every four weeks. This meant that staff will be regularly updated in patient safety incidents and practice changes to improve care.

The issues raised on the Patient Safety Boards were standing agenda items at ward meetings. One ward manager and a non executive director we spoke with told us that staff carry out their patient handovers at the patient safety board to ensure that patient safety is an integral part of the procedure, which we felt was good practice. Learning from incidents was disseminated to all staff via email and the trust's intranet system. Staff knowledge and awareness was being tested through ‘check and challenge’, a new system of regular spot checks carried out by a member of the executive team, such as the director of nursing, a doctor and a matron. Most of the wards we visited had received such a visit but those that had not were aware of the programme. We saw examples of presentations, emails and minutes of risk meetings which showed that doctors were being fully included in these practice changes. All staff with whom we spoke with embraced the programme. We, therefore, found a changing cultural shift
amongst all grades of staff at the trust in respect of patient safety, incident reporting and learning.

We had raised concerns at the last inspection in June and July 2012 about insufficient initial assessment practices and failures to recognise deterioration in patients. At this inspection on the 04 September 2012 we could see regular daily and weekly continuous checks on assessment practices being actioned throughout the clinical areas in the hospital. The results were being reported to each directorate and the board of directors. We saw an example of a ward where they were not fully compliant with the patient at risk scoring system and actions had been taken with further checks put in place showing they were now compliant. We were told that ongoing monitoring would be maintained which will encourage continuous improvements in assessment practices throughout the trust.

The senior executive team had made it clear to all the nurses and doctors that they were responsible and accountable for documenting assessment and patient at risk scores accurately. There had been increased training and awareness sessions for all relevant staff in the management of the deteriorating patient. Staff we spoke with were knowledgeable about assessment practices and we saw that the check and challenge spot checks included testing their understanding regarding the deteriorating patient. This means that there was now an effective system operating to allow the trust to regularly assess and monitor the quality of the services it provided, in relation to patients going into rapid deterioration.

The provider had made clear improvements in developing a quality assurance system to help them assess the health, welfare and safety of patients. The provider had recently appointed a new chair of the board and a new chief executive. The Care Quality Commission and other involved agencies will continue to monitor the trust to ensure the improvements are sustained.

**Our judgement**
The provider was meeting the standard.

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