Review of compliance

Basingstoke and North Hampshire NHS Foundation Trust Basingstoke and North Hampshire Hospital	
Region:	South East
Location address:	Aldermaston Road Basingstoke Hampshire RG24 9RH
Type of service:	Acute services with overnight beds Community healthcare service
Date of Publication:	September 2011
Overview of the service:	Basingstoke & North Hampshire NHS Foundation Trust was created on 1st December 2006. Basingstoke & North Hampshire Hospital is the sole location registered for the trust and is located on the outskirts of Basingstoke. It is a general acute hospital that provides a full range

	of adult, paediatric and maternity clinical specialties. The hospital serves a population of around 300,000 patients and has 450 beds. It is currently registered without conditions.

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

Our current overall judgement

Basingstoke and North Hampshire Hospital was meeting all the essential standards of quality and safety.

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 06 - Cooperating with other providers
Outcome 08 - Cleanliness and infection control
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 18 - Notification of death of a person who uses services
Outcome 20 - Notification of other incidents
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 23 May 2011, carried out a visit on 24 May 2011, checked the provider's records, talked to staff and talked to people who use services.

What people told us

Most patients we spoke to were generally positive about their experience of the care at the hospital.

The parents of patients on the children's ward were very positive about the care and the nursing staff.

Patients and their relatives told us that visitors had been made welcome on the wards and they had space to talk privately.

All of the patients we spoke to told us that they saw the domestic staff cleaning the ward areas every day.

What we found about the standards we reviewed and how well Basingstoke and North Hampshire Hospital was meeting them

Outcome 04: People should get safe and appropriate care that meets their needs

and supports their rights

The trust provides safe and appropriate, personalised care, treatment and support.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard

Outcome 06: People should get safe and coordinated care when they move between different services

The trust cooperates with others involved in the care, treatment and support of patients and works with community partners to improve the patient experience of care.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

The trust ensures that there are systems and processes in place to prevent and control infection. Staff have access to training, guidance and support. Monitoring of compliance with infection control standards, policies and procedures is taking place and information is communicated to staff at all levels and to the Board of Directors.

Some equipment used at the trust is not kept clean whilst being stored and some bed tables have damaged surfaces which cannot be cleaned properly and need to be replaced.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting 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 appropriate systems to monitor the quality of services that patients receive. It has systems in place to ensure that the quality of experience of patients is measured, improvements identified and action taken to implement those improvements.

However, the trust's systems for coding data and ensuring correct information is sent to the Commission via national data collection systems for reporting purposes are not robust.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard.

Outcome 18: Adult social care and independent healthcare services must tell us when somebody dies in their care. NHS services must tell us when somebody dies because they have not been given the right care

The trust has not notified CQC without delay of the death of people who use the service

but has now put processes in place to improve its performance. To ensure compliance in the future, the trust must sustain improvements in the notifications of deaths to the Commission.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard.

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

The trust has not notified CQC without delay of serious incidents but has now put processes in place to improve its performance. To ensure compliance in the future the trust must sustain improvements in the notifications of incidents to the Commission.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The trust ensures that medical records are accurate, held securely and remain confidential.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard.

Other information

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 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
During our visit to the trust, we spoke to patients and their relatives. Most patients we spoke to were generally positive about their experience of the care at the hospital. We spoke with three patients on the medical ward, two on the orthopaedics ward, two relatives who were visiting patients and three parents of patients on the children's ward. Two patients said the care was 'fabulous' or 'brilliant' and the nursing staff were always helpful. Another person said some nurses were better than others.

One patient said that when they rang their bell for help in the night, the staff could take a while to respond and made them feel awkward by asking why they required help. Most patients said that staff were responsive and helpful and one relative said that her anxiety about her husband's operation and care had been reduced because she knew that "staff were on top of things".

The majority of patients agreed that the staff had asked them about their care needs at the time of admission or shortly afterwards. One person said they could not remember being asked about their needs. Two patients remembered being asked about their religious and cultural needs and whether they had any disabilities.

Two patients told us the doctors were "brilliant". They said the doctors had explained everything in a way they could understand and they had opportunities to ask questions. One person said there were not enough doctors available during the weekends and this had caused them some delay in getting the advice they needed.

The parents of patients on the children's ward were very positive about the care and the nursing staff. They told us the nursing staff were approachable and always willing to help. Two parents said they had been asked about their child's needs and another said they had not. One parent said it took a few days after their child's admission for the staff to explain any plan of care.

Patients and their relatives told us that visitors had been made welcome on the wards and they had space to talk privately. The patients said they had been given information about visiting when they were admitted and there were signs around the ward. The parents of patients on the children's ward said that the hospital staff had thought about the needs of families.

One person said the physiotherapist had given them advice and showed them the exercises they needed to help their recovery.

One patient told us that his experience of care and treatment at the hospital had been much better on this occasion than he had experienced when he had an operation at the hospital 18 months previously. He said that he had seen more senior nursing staff on duty and he felt they made a positive difference.

Other evidence
During our visit, we looked at some patients' records and saw that they all contained admission forms which recorded information about patients' individual needs including a record of their religious and cultural needs. Not all of the admission forms we saw had been completed fully on admission. The matron on one ward told us that it was normal practice to speak to patients when they were admitted and ask about their needs and preferences. One matron told us that senior nursing staff had recognised that the admission forms were not always "working well" and they were considering introducing a simpler admissions form. This matron also said that if the patient had been transferred from another area of the hospital, their admission forms would come with them and the nurses on the new ward should review and update them. We found that although this had been done in some areas they were not all completed consistently.

One matron said the staff were encouraged to sit with the patients daily while they wrote up their notes and to try to involve the patients whenever possible.

The matron explained that some wards in the hospital had introduced a new way of checking every patient every one to two hours. These checks included, if the person was in pain, whether they had enough to drink, if the person needed the toilet and the regular observations of their blood pressure and pulse. The nurses also made sure the patients were comfortable and helped them to move position. The matron said this had proved to be a useful way of checking the quality of the care and it was also reassuring to the patients to know a nurse would regularly check on them. The matron explained that since this system of checks called "rounding" had started the amount the patients rang their call bells had reduced by 50%.

Senior staff told us they had regular handovers between staff during the day and the matrons usually went around the wards every day to ask the patients if they were satisfied. Three patients confirmed this had been happening during their stay.

We saw evidence that the patients had access to other relevant health care

professionals including physiotherapy and dieticians. These staff had written their findings in the patients' records.

One senior matron explained how the wards made relatives feel welcome and they said there was a room where people could stay and be comfortable if their relatives were very ill. This matron said it would be easier for relatives to make meals and drinks when they moved to a new care facility planned on the hospital site.

In the self-assessment the trust completed prior to our visit, the trust provided us with evidence of their patient risk assessments, which included detailed assessments of risks such as moving and handling for each patient. During our visit, we saw completed risk assessments in the patient records we checked.

The trust's self-assessment included copies of minutes of the trust's Patient Experience Group meetings and copies of "patient focus" reports for different wards. These showed that the trust responded to comments and feedback from patients, relatives and staff and used the information to improve the care they were delivering. For example, one patient had commented that it would be helpful to be given more information regarding the routines in the hospital such as meal times and visiting times. In response, the trust produced a laminated information card which had been placed at each bed side.

One matron explained how they responded to any complaints and that an action plan was developed and the process was explained to the complainant. This matron also said they spent time talking with the patients and some minor concerns raised during these conversations could be responded to very quickly. The senior nursing staff we spoke to said that they reviewed all complaints made about their wards and looked for any common themes to decide if there was a way to improve the service as a result.

During our visit, we saw nominations by patients and patients' relatives of nursing teams for the trust's Director of Nursing award which praised the quality of care and nursing provided on various wards.

Prior to our visit, the 2010 Dr Foster Hospital Guide (an annual report produced by the independent provider, Dr Foster, of comparative information on health and social care services) reported that the trust had coded 45.5% of deaths in 2009/10 as deaths of patients in palliative care. The trust had the highest percentage of deaths attributed to patients in palliative care in England. In November and December 2010 there were some concerns raised in the media that the trust may have attributed too high a percentage of deaths to patients in palliative care. A high percentage of deaths coded as palliative care could have the effect of reducing the Hospital Standard Mortality Ratio (HSMR). The HSMR is a measure of overall mortality for a trust and, in general, a high mortality ratio would be a trigger for further investigation to identify the reasons behind the figures. We met with senior trust staff to discuss the concerns raised by the Dr Foster report in December 2010 and the trust provided us with further information in their self-assessment for this review.

The trust provided us with assurance that it had coded as palliative care all patients that had been placed on the Liverpool Care Pathway. The Liverpool Care Pathway is a plan for end-of-life care designed to increase the quality of nursing expertise at the end of life and it is recommended by the Department of Health as the best practice model for

care of the dying. The trust supplied us with evidence that they gave considerable focus to end of life care and their comparatively high use of the Liverpool Care Pathway was in response to this focus. For example, the trust appointed an end of life care facilitator and administrator, raised awareness about the importance of end of life care amongst staff by using End of Life link nurses (nurses identified in each ward to work closely with the palliative care team) and champions (non-clinicians) and collected feedback via an end of life questionnaire given to all bereaved relatives. The trust had trained staff to identify when patients were at the end of life and to ensure they and their families received appropriate end of life care. The local Primary Care Trust confirmed to us that they believed the reporting of deaths was appropriately managed by the trust and there were no clinical issues of concern. Our internal analysis of the trust's mortality data assured us that the trust's mortality ratio was within acceptable limits.

In their self-assessment, the trust also provided us with information regarding their systems for learning from adverse events and incidents and we discussed these systems with senior trust staff during our visit. We found that the trust had a comprehensive internal system which carried out service reviews and reported outcomes and findings through a range of trust groups, committees and management structures. For example, the trust held clinical issues meetings to look at clinical areas of concern and adverse incidents. Also, the trust had set up a Serious Event Review Group to investigate and learn from serious events and incidents. The trust ensured that learning and actions from service reviews and incidents were reported via the trust's Governance Report which was presented monthly to the trust's Board of Directors and were communicated to departmental, clinical and ward groups.

Our judgement
The trust provides safe and appropriate, personalised care, treatment and support.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard

Outcome 06:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
* Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
We did not discuss this outcome area with patients so cannot report what they said.

Other evidence
Prior to our visit, we had received two concerns from local care homes regarding patients who had been transferred to them from the hospital with pressure sores that had not been identified by the hospital in their discharge information. We saw the trust's internal investigations and responses to both incidents which included matrons from the trust meeting with the specialist nurse for care homes and improved training in pressure sore identification and management for nursing staff. The trust also demonstrated that they had improved the discharge information provided to patients and other providers involved in the care of patients as a result of these incidents. A number of nurses we spoke to said that they felt that it had been very helpful to them that they had met and received training from the tissue viability nurse.

One senior nurse said there was some difficulty getting all the information about a patient when they were admitted from a nursing home. She said that to improve this there had been a recent meeting with a senior community nurse and they had agreed that the staff member from the nursing home who accompanied the patient on admission would be involved in completing the admission assessment. For example, there was an agreement that when a patient was admitted with any pressure sores, both the person that accompanied them and a nurse from the ward would check to see the condition of any sores and ensure this was recorded.

In the self-assessment the trust provided, they stated that there was a daily (week-days) multi-disciplinary team meeting to discuss the discharge of elderly patients with ongoing care needs in the community. The trust also stated that they managed complex discharges from hospital through an integrated discharge team which was a joint team. This joint team included in its members staff from the local mental health trust, local authority staff, and local community health care staff as well as trust members. We saw that, since implementing the integrated discharge team, the trust had improved its performance in meeting delayed transfer of care targets.

The ward staff we spoke to said that they had seen an improvement in the communication with community teams over the past few years and that they had a better understanding of any issues causing delays to discharges. One nurse told us that it was easier to explain to patients and relatives when discharges were delayed because they had the information from the community services and other external partners to give to the patients. Patients we spoke to on the elderly care wards who were waiting to be discharged understood why they could not be discharged immediately and were well informed regarding the plans being put in place for them for community social and/or health care.

We saw the trust's business continuity plans in the event of a major incident or emergency situation and saw that they involved other providers such as the ambulance service, community health and social care teams and other acute trusts in planning for major incidents including participating in emergency drills.

Our judgement
The trust cooperates with others involved in the care, treatment and support of patients and works with community partners to improve the patient experience of care.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
During our visit, we spoke to patients in each of the areas visited about cleanliness of the hospital and hand washing practices of the staff. All the patients advised us that they saw the domestic staff cleaning the ward areas every day.

One person said, "The cleaners do a good job." This same person said that all the nurses washed their hands before carrying out care and afterwards, but that, "sometimes, the cleaners do not." There were no other concerns expressed about the standards of cleanliness and the patients who spoke to us were happy with hygiene practices of the staff.

Other evidence
In January 2011, the trust reported that they were experiencing high cases of norovirus and visiting restrictions were in place. In March 2011, the trust had more cases of norovirus and declared the norovirus outbreak to be a serious incident. Basingstoke and North Hampshire Hospital continued to see cases of norovirus until the end of April 2011. The trust provided us with a report on their management of the norovirus outbreak as part of their self-assessment. The trust implemented a range of control measures to manage the outbreak including the closure of affected wards, restrictions to visiting hours, additional cleaning, daily visits by the trust's Infection Prevention and Control Team to affected areas and additional hand washing and protective equipment requirements. The outbreak was managed by a multidisciplinary team which met daily (the Silver Command meeting) to review the situation.

In March 2011, the trust was assigned an Amber-Red risk rating for the third quarter of 2010-11 by Monitor (the independent regulator of NHS foundations trusts) because it

had breached the target for clostridium difficile cases (cumulatively) for the third consecutive quarter. The analysis we carried out on clostridium difficile rates at the trust as part of this review showed that despite a clear reduction in the levels of infection since April 2007 the rates were still higher than expected. This Amber-Red risk rating has now been reduced by Monitor. The trust had no cases of methicillin resistant staphylococci aureus (MRSA) infection in 2010-11 and 2011-12.

During our observations on the visits and from discussion with staff, we were able to check the systems in place for managing infectious outbreaks. There was access to a single room for isolation purposes. When such rooms were unavailable, there was a process in place for caring for patients in bay areas, following recommended practices for minimising the risk of spread. We were able to see correct signage in place indicating that side rooms were being used for isolation purposes.

During our inspection, we visited two wards and the Emergency department. On the first ward, cleaning activities were in progress when we arrived. We noted that the domestic staff were using the national colour coded equipment to undertake their cleaning duties and they had a good supply of equipment to assist them in performing the tasks. Whilst undertaking their cleaning duties, we noted that staff wore protective items of clothing, including aprons and gloves. These were disposed of correctly after use.

On both wards we visited, we were also able to see that there were detailed instructions for the cleaning to be carried out in each separate bay area or room within the ward. Domestic staff outlined their cleaning responsibilities for areas within the ward, such as storage rooms, clean and dirty utility rooms, storage areas, toilets and bathrooms. The format of the cleaning records required the signature of the person who had cleaned the area, and we were able to see evidence of the completion of this in the ward areas we visited. Staff told us the domestic supervisor monitored cleaning standards and that environmental checks were carried out at regular intervals.

Within each separate bed area, we identified a bed area checklist that nursing staff were responsible for completing. This listed equipment in the immediate area and a signature was required when the items had been checked and cleaned. We checked that the items listed were suitably clean and found that there were no concerns, with the exception of slide sheets, used for the transfer of patients and to enable patients to be moved safely in bed. These were being stored at the bed head on ward F2. The majority of these inspected were noted to be dusty. Commodes, located in both wards were checked for cleanliness during our visit, and all were found to be clean and ready for use.

When we arrived at the second ward, cleaning activities had been completed for the morning. We looked at the whole ward area and in particular, immediate areas around the patient beds, and noted that these areas were clean. Equipment located close to patients was found to be clean. On both wards, we did identify that some of the bed tables were in need of replacement, as the surfaces were damaged and therefore could not be cleaned fully. Staff on the second ward we visited advised that new tables had been ordered.

During our observations, we observed the staff correctly disposing of clinical and non-clinical waste. Soiled linen was seen to be managed correctly. Clean linen was stored

separately and was available in good supply to enable care needs to be met.

We asked staff how they knew how to clean equipment that was being used by patients. Some staff advised us that there was guidance supplied from the equipment library or in the local policy. Others did not make reference to the policy, indicating that they knew by experience.

We spoke to a number of staff, including clinical and domestic staff working on both wards. Staff confirmed that they had received training in infection control. The lead nurse for infection control had delivered the training. On one of the wards, staff told us that they had staff who worked with the Infection Prevention and Control Team to provide support and information about infection control. In addition, these staff were said to be involved in auditing infection control measures, such as hand hygiene standards and the cleaning of commodes. Staff working in both wards described the processes for auditing and told us that results of such audits were communicated to them. We saw results of recent audits on display and were also provided with a copy of the results of the infection control audit for ward E1. A target had been set for compliance of 85% and the ward exceeded this, achieving 88%. The report included recommendation for actions and staff were required to supply an action plan to the infection control team within the following month.

We were able to speak to the director for infection prevention and control, (DIPC), about the systems and processes in place for overseeing infection control. We were told that there was an infection control team and regular meetings took place with these members. Information related to infections, audit results and other relevant information was discussed and produced in formal reports, which were made available to the Board of Directors. The DIPC confirmed that there were identified leads for decontamination and for the cleanliness of the environment. We were provided with a copy of the local policy for cleaning and noted that this was a detailed document that provided guidance to staff in all areas and outlined responsibilities of staff.

With regard to training, the DIPC indicated that there was a formal process for monitoring and managing training attendance. The provision of infection related training to consultants was carried out by the DIPC and junior doctors had information as part of their formal training. Training for non-clinical staff was undertaken though an e-learning process. Voluntary staff received infection control training as part of their induction.

Our judgement
The trust ensures that there are systems and processes in place to prevent and control infection. Staff have access to training, guidance and support. Monitoring of compliance with infection control standards, policies and procedures is taking place and information is communicated to staff at all levels and to the Board of Directors.

Some equipment used at the trust is not kept clean whilst being stored and some bed tables have damaged surfaces which cannot be cleaned properly and need to be replaced.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting 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

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 discuss this outcome area with patients so cannot report what they said.

Other evidence
In the trust's self-assessment, they provided us with copies of the monthly Governance Reports which were presented to the trust's Board of Directors. The Governance Reports included quality measures for clinical effectiveness; patient safety and patient experience. The data included the trust's performance against external targets such as those set by the Primary Care Trust, Monitor and the Department of Health. The Governance Reports also included information on the actions being taken to address the areas identified in the quality reports where the trust was not performing well.

For example, the reports showed that at the start of the 2010-11 financial year, the trust each month had a small number of breaches of the same sex accommodation requirements set by the Department of Health (the requirement to ensure that no patients are in mixed-sex accommodation). The data showed that in April 2010 there were nine breaches, in May 2010 there were six breaches and in June 2010 there were ten breaches. The trust's Governance Reports indicated that all same sex breaches were investigated and the matron for the area responsible identified any changes required which were discussed at daily bed meetings. We saw that the number of breaches each month reduced across the course of the year and there were no breaches recorded between January and March 2011.

The trust provided us with detailed evidence of the different methods they used to

gather information about the safety and quality of their service. We saw the results of the Patient Satisfaction Survey carried out in 2010 in the Children's Health department. This showed very positive responses from children and adult respondents, particularly with regard to the friendliness of the units and the medical information that was given directly to children and not just discussed with their parents or carers. We saw the findings of the Patient Observation Chart Audit of September 2010, which identified areas of good practice such as the performance of wards D2 and D4 which had over 90% compliance with the audit standards. The Audit also made recommendations for improvement for areas of poorer performance such as recording the frequency of observations on patients' charts.

We saw evidence that the trust carried out regular patient safety checks (called "walkrounds") across different wards and departments and the issues identified were followed up with the relevant departments by the trust's Patient Safety Manager. For example, we saw that the patient safety walkround for Gynaecology and the Early Pregnancy Assessment Unit carried out in March 2011 identified that the unit's patient call bell system needed improvement. We saw confirmation that the Patient Safety Manager had raised the issue with the department which was sourcing a new call bell system, but, in the interim, had received funds to purchase additional call bell pendants to ensure each bed space had a working call bell.

During our visit, we spoke to senior trust staff including some of the trust directors. The trust directors we spoke to explained clearly their role in ensuring the quality and performance of services provided by the trust. For example, they informed us of their incident reporting structure, which included mandatory training for all staff in incident reporting; reports sent to all departments and consultants identifying any trends in incidents; and reports to the Board of Directors of all incidents. The trust's medical director advised he presented the Governance Report to the Board of Directors each month. We saw copies of Governance Reports which included information on all incidents trust-wide and outcomes of investigations into serious incidents and recommendations made by the trust's Serious Event Review Group.

The trust directors gave us examples of improvements that had been made as a result of incident reporting. They advised that the trust had recently invested in an electronic prescribing system in order to reduce the level of medication errors. The errors had been highlighted to the board by the incident reporting system. Also, the trust had held a serious incident review into a case of a pregnant oncology patient who had died after being transferred to another hospital for specialist oncology treatment. The serious incident review identified that the trust needed to improve its processes with regard to transport and training in the sick obstetric patient. The directors we spoke to informed us that the trust had subsequently improved its transport processes and increased training in sick obstetric patients as a result of the serious incident review.

During our visit, we saw displayed publicly on ward notice boards and other areas around the hospital, detailed information on the performance of the hospital and individual wards in meeting different performance targets. This included the trust's internal monitoring of their compliance with the essential standards of quality and safety. The trust also had detailed information available on its website regarding its performance. For example, the trust's website reported the incidence of clostridium difficile infections and methicillin resistant staphylococci aureus (MRSA) bactereamia and provided information for the public regarding its performance against its targets for

these areas (the trust was meeting the targets at the time of our visit). The website also contained information regarding the trust's performance in meeting national targets set for waiting time in the Accident and Emergency department and its performance against the national targets set for cancer treatment. The trust's performance exceeded the standards set by the Department of Health in both these areas at the time of our visit.

During our review, our analysis of the trust's end of life care reporting and incident reporting (detailed above under outcomes 4, 18 and 20) indicated concerns regarding the trust's processes for coding data. The trust confirmed to us that it had been using an incorrect code for reporting deaths in end of life care (code Z51.5). The Connecting for Health Coding Clinic Guidance produced in June 2010 stated that this code should only be used when the specialist palliative care team had been involved in a patient's end of life care. However, the trust had used the code for all deaths of patients on the Liverpool Care Pathway, not all of which had specialist palliative care team input.

The trust's self-assessment stated that a high number of electronic reports of incidents were returned to the trust from the NPSA (National Patient Safety Agency). This had resulted in a backlog of electronic incident reports that the trust had to review and resubmit. The trust confirmed that there had been delays in reviewing and resubmitting the backlog. The trust reported to us the findings of its investigation into this issue which identified that there had been errors in reporting and in some cases poor quality reporting. The self-assessment also stated that the trust had produced an action plan to improve the quality of reporting. The action plan included actions to increase staff awareness; to process the backlog; to improve the trust's incident reporting form; and to make Divisional Governance Leads responsible for the quality assurance of reporting within their division.

In May 2011, we alerted the trust to an analysis of maternal emergency readmissions which we had carried out for all trusts. Basingstoke and North Hampshire Hospital had significantly high rates for maternal emergency readmissions within 28 days of delivery. We asked the trust to send to us their analysis of the readmission rates and also asked them to advise why a large proportion of data referring to gestational period was missing for deliveries at their trust. The trust's response informed us that many of the readmissions were due to well mothers being admitted with sick babies. The trust had amended its processes to admit mothers with sick babies but had not amended the codes used when reporting these readmissions. The trust confirmed in its response that they would in future use the secondary code Z763 which identifies a healthy person admitted with a sick person when reporting these readmissions. The trust confirmed that there had been issues with the data sent through by their reporting system in 2010/2011. The trust reported the system had been upgraded and in April 2011 there were significantly fewer errors in the data sent.

These reporting and coding issues meant that records about care provided at the trust were not accurate and had all resulted in incorrect data being provided to mandatory national data collection systems and then to the Care Quality Commission.

Our judgement
The trust has appropriate systems to monitor the quality of services that patients receive. It has systems in place to ensure that the quality of experience of patients is measured, improvements identified and action taken to implement those improvements.

However, the trust's systems for coding data and ensuring correct information is sent to the Commission via national data collection systems for reporting purposes are not robust.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard.

Outcome 18:
Notification of death of a person who uses services

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that deaths of people who use services 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 18: Notification of death of a person who uses services

Our findings

What people who use the service experienced and told us
We did not discuss this outcome area with patients so cannot report what they said.

Other evidence
In May 2011, we analysed the number of notifications of deaths received from the trust between 1st November 2010 and 16th May 2011. In this period, we had not received any notifications of deaths. However, during this time, the trust had informed us in regular communications of incidents and deaths such as stillbirths and, yet, these had not been followed up with formal notifications as per Regulation 16 of the Health and Social Care Act 2008 which requires providers to notify the Commission without delay of the death of a service user.

During our visit, we looked at the trust's incident reporting policies and case-tracked some incident reports. We found that the trust's internal incident review and reporting structure was detailed and comprehensive and that the trust was producing the incident data and reporting for the Primary Care Trust and Strategic Health Authority. We also found that the trust was sending notifications of deaths to the National Patient Safety Agency (NPSA). However, we identified that there were gaps in the trust's notifications policy with regard to the coding of some notifications. We discussed this issue with senior trust staff including the head of governance and medical director. We found that incidents of death that should have been notified to CQC (via the National Patient Safety Agency notifications system) had not been correctly coded by the trust when the notifications were being entered into the computer system. Therefore, the NPSA had not sent on these notifications to CQC because they did not contain the codes the

NPSA recognised that need to be sent on to CQC.

After our visit, the trust provided us with an action plan to achieve compliance with this outcome.
The action plan included an action to ensure that all applicable death notifications would be correctly coded with immediate effect and that the trust would immediately introduce a two-stage internal quality assurance process. The action plan also included an action to amend the incident reporting policies to meet the regulatory requirements.

The trust advised it would review and amend the coding of notifications of deaths immediately. In June 2011, CQC received nine notifications for the period January – June 2011 indicating that the trust had taken action to improve.

Our judgement
The trust has not notified CQC without delay of the death of people who use the service but has now put processes in place to improve its performance. To ensure compliance in the future, the trust must sustain improvements in the notifications of deaths to the Commission.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting 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 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 did not discuss this outcome area with patients so cannot report what they said.

Other evidence
In May 2011, we analysed the data we had for notifications of incidents received from the trust between 1st November 2010 and 16th May 2011. We had received 32 notifications of incidents from the trust in that period. Our analysis showed that there were significant delays between the dates the incidents occurred and the dates that we received the notifications. 50 per cent of deaths and severe harm incidents (these two categories were put together for the analysis, but as reported under outcome 18 above there were no notifications of deaths received from the trust) were reported within 244 days compared to an average of 32 days for other trusts. Regulation 18 of the Health & Social Care Act 2008 requires providers to notify the Commission without delay of specified incidents.

During our discussions about notifications with trust staff, we found that severe incidents were also not being correctly coded by the trust to ensure that they would all be sent by the NPSA to CQC.

Whilst checking incident reports during our visit, we found that the trust was carrying out its internal investigations into incidents prior to sending through the notifications to the NPSA resulting in a delay in the notifications being sent. For example, one incident report was dated 17th January 2010 and the date it was reported to the NPSA was 27th April 2010. We saw very detailed and thorough incident reports and investigations

which included key learning points for the trust when serious incidents had occurred. We saw minutes of Board meetings where the outcomes and learning points from incident reviews had been reported. The trust's senior staff members advised that the trust's policy was to investigate incidents prior to sending through the notifications in order to ensure the correct information regarding the incident was included.

In the notifications action plan that the trust sent us after our visit, they advised they would immediately change their process for notifications to ensure that notifications of incidents would be sent through as soon as possible instead of waiting until internal investigations of incidents had been completed. They also advised that they would provide additional support and training to staff in the reporting requirements and would carry out regular audits to monitor their performance.

In June 2011, CQC received 88 notifications of incidents from the trust for the period January – June 2011 indicating that the trust had taken action to improve the notification of incidents.

Our judgement
The trust has not notified CQC without delay of serious incidents but has now put processes in place to improve its performance. To ensure compliance in the future the trust must sustain improvements in the notifications of incidents to the Commission.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential standard.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not discuss this outcome area with patients so cannot report what they said.

Other evidence
During our visit, we reviewed patients' medical records on three wards. We saw that the records were kept securely in the ward offices and were easily located by ward staff when needed. The records we saw had been regularly updated by the healthcare professionals involved in the patients' care and treatment.

The trust stated in their self-assessment that they had many policies relating to recordkeeping, in particular a Health Records Policy, an Access to Health Records Policy, a Transportation of Health Records Policy and policies regarding electronic records. All of the trust's policies were available for us to review during our visit to Basingstoke & North Hampshire Hospital. We also saw the Trust's standard operating procedures for archiving medical records and for the destruction and retention of patient case notes. These procedures complied with the requirements for keeping or disposing of healthcare records.

The trust gave us a copy of their information leaflet for patients regarding healthcare records. The leaflet explained what information was kept by the trust, how it was used and stored and how patients could access their healthcare records. During our visit, to the hospital we saw copies of the information leaflet on all wards we visited.

The trust provided us with a copy of the report of their trust-wide audit of health care records dated December 2010. As part of this audit, 81 medical records were audited, chosen by random for a selection of records of patients discharged in July 2010. The audit looked at the level of compliance with the standards of recording set out in the trust's Health Records Policy and identified good practice and key areas for improvement. For example, the audit found 80% of entries were dated but only 34% had the time fully recorded. We saw that the results of this audit were communicated to all staff via the trust's Quality Matters newsletter.

Our judgement
The trust ensures that medical records are accurate, held securely and remain confidential.

Overall, we found that Basingstoke and North Hampshire Hospital is meeting this essential 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.

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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