PATIENT SAFETY ALERTS:

IMPLEMENTATION; MONITORING; AND REGULATION IN ENGLAND

FEBRUARY 2014

Background

Patient Safety Alerts are instructions on how to limit the risk of known repeated problems which cause harm in healthcare re-occurring. The vast majority cover problems which have been proven to repeatedly cause serious harm or death. Examples include misplacing of naso-gastric tubes; problems with high-risk drugs; and operating on the wrong patient or wrong part of the body. They are supposed to be mandatory. Trusts are supposed to comply with the required actions by a deadline agreed by a panel of experts.

Patient Safety Alerts used to be developed and issued by the National Patient Safety Agency (NPSA) drawing on evidence from the national reporting system for adverse incidents. The NPSA has since been abolished, but the alerts themselves and the requirement to comply with them have not changed in status.

NHS England is now responsible for new Patient Safety Alerts.

The raw data on which this report is based can be found here:
http://www.avma.org.uk/data/files/PSA_Copy_of_NPSA_data_Jan_14_Outstanding_alerts.xls

Information on the detail of each alert can be found here:
http://www.nrls.npsa.nhs.uk/resources/type/alerts

Summary of Key Findings

- **Since our first report in February 2010, there has been a dramatic improvement in compliance with existing patient safety alerts. There were 141 instances of non-compliance with alerts in January 2014 compared with 455 in our last report in August 2011 and 2,124 in February 2010.**

- **However, every alert not complied with represents a serious risk to patients, and there are 14 examples of trusts who have still not complied with 3 or more patient safety alerts for which the deadline is past**

- **There were 13 cases where the deadline has been exceeded *by over 5 years*.**

- **The worst rate of compliance was at Southend University Hospital NHS Foundation Trust, which had not complied with 7 alerts, including 2 alerts which were over 5 years past the deadline and 2 alerts which were over 3 years past the deadline.**

- **Southend University Hospital NHS Foundation Trust had received no formal warnings or instructions to comply with patient safety alerts from the Care Quality Commission or from commissioners of its services. The issue of its ongoing non-compliance with patient safety alerts had not even been discussed at the trust's board meetings. Neither is it mentioned in the latest available version of Quality Accounts (2012-2013).**

- **The Care Quality Commission could provide no record of taking up the issue of patient safety alerts with Southend, in spite of being aware of how extremely overdue they were. In its current online report on the trust the CQC gives it a completely clean bill of health, including for safety, and assessing and monitoring safety, based on its inspection in October 2013.**

FINDINGS:

Implementation of Patient Safety Alerts as at January 2014

AvMA obtained the **latest data on implementation of Patient Safety Alerts** from the Central Alert System. The data can be accessed here:
http://www.avma.org.uk/data/files/PSA_Copy_of_NPSA_data_Jan_14_Outstanding_alerts.xls
It showed that as of 30th January 2014 there were:

- 141 instances of a patient safety alert not having been complied with
- 83 trusts are recorded as not having complied with at least one alert
- 14 trusts had not complied with at least three alerts
- 17 instances of alerts which had not been complied with which were over three years past the deadline
- 13 instances of alerts which had not been complied with which were over five years past the deadline.

Appendix 1 provides a list of trusts with outstanding alerts in alphabetical order with the number of alerts outstanding.

Appendix 2 provides a list of trusts in descending order, with the trusts with the most alerts outstanding at the top.

It should be noted that one of the alerts (Safer Spinal (intrathecal), epidural and regional devises (Part B), may not be possible to implement in full, as we understand that the equipment required to comply is not currently available. If this alert is not considered as 'not complied with' the rate of compliance overall is improved considerably.

Case Study: Southend University Hospital NHS Foundation Trust

Southend University Hospital NHS Foundation Trust had the highest number of patient safety alerts which had not been complied with: 7.

- These included 2 which were over 5 years past the deadline:
- There were another 2 which were over 3 years past the deadline.

Examples of Outstanding Alerts at Southend:

"**Actions that make anti-coagulent therapy safer**"
http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59814&p=3

Issued: 28th March 2007
Deadline for completion: 31st March 2008
Rationale: *"Anticoagulants are one of the classes of medicines most frequently identified as causing preventable harm and admission to hospital"*

"Promoting safer use of injectable medicines"
http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59812&p=3

Issued: 28th March 2007
Deadline for completion: 31st March 2008
Rationale: *"The National Reporting and Learning Service received around 800 reports a month relating to injectable medicines …. There were 25 fatal incidents and 28 of serious harm"*

"Safer administration of insulin"
http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=74287&p=1

Issued: 16th June 2010
Deadline for completion: 11th December 2010
Rationale: *"Errors in administration of insulin are common. In certain cases they may be severe and can cause death".*

AvMA made a Freedom of Information Act request to find out what discussions had taken place with the trust about complying with Patient Safety Alerts and what communication they had received from the Care Quality Commission or commissioners of services about their ongoing non-compliance. The trust's response can be found in Appendix 3. We were shocked to find that:

- The trust had received no formal warnings or instructions to comply with alerts either from the CQC or from commissioners.
- The trust's board had not discussed the situation regarding the ongoing non-compliance with alerts.

- The trust's 'Quality Accounts' report for 2012-2013 makes no reference to its ongoing non-compliance with alerts.

We were supplied with copies of minutes of the trust's Clinical Assurance committee. Membership includes the Medical Director, and this committee did receive reports on outstanding alerts on a regular basis. However, it appears that ongoing non-compliance going back years was never escalated to the board.

After seeing a draft of our report, the trust has since contacted us to say that they now believe they are compliant with all of the alerts. There is no way of us verifying whether this is the case, but even if it were, it does not change the fact that its own belief that it was not compliant failed to spark action by its own board or regulators or commissioners for a period of years.

Case Study: The Care Quality Commission

The CQC is the national regulator of healthcare organisations for England. CQC had been made acutely aware of its failures to take sufficient notice of non-compliance with Patient Safety Alerts as a result of our earlier reports in 2010. Six months after publication of our first report we found that CQC had done nothing about this issue, which was even more widespread then. The CQC pledged to do better. At our suggestion, CQC agreed to at least write to some of the worst performing trusts regarding Patient Safety Alerts. It also began to take some account of compliance with alerts as part of its "quality and risk profile".

AvMA made a Freedom of Information Act request to the CQC to establish (a) if they had done anything between February 2010 and October 2013 to take up the issue of non-compliance with Patient Safety Alerts with Southend University Hospital NHS Foundation Trust and (b) whether there had been any formal internal discussions or reports within CQC about how it should be dealing with trusts which do not comply with alerts.

The response from CQC (see Appendix 4) confirmed:

- No formal communication had taken place with Southend University Hospital NHS Foundation Trust on this matter at all.

- There had been no formal internal consideration at CQC of how to deal with non-compliance with Patient Safety Alerts generally.

As a result of reviewing CQC's website http://www.cqc.org.uk/directory/raj01 (see Appendix 5), information on **Southend University Hospital NHS Foundation Trust**, we found that:

- as of 6th February 2014 CQC gave a complete clean bill of health to the trust. In spite of knowing about the 7 Patient Safety Alerts which had not been complied with, CQC makes no reference to this.

- the CQC had inspected Southend University Hospital NHS Foundation Trust in October 2013. Its report makes no reference to long-term non-compliance with Patient Safety Alerts.

In correspondence following our Freedom of Information request, the CQC acknowledged that it knew which of the alerts reports had not been complied with when it inspected the trust in May 2013 and October 2013, and reported that the trust was meeting CQC standards. This was in spite of the fact that in May 2013 the inspector noted:

"No indications on how these issues/risks are being safely managed before the alerts are implemented. These have been seen to be reviewed at CAC (Clinical Assurance Committee) and there is acknowledgement that it will affect CQC standards".

The CQC now tell us that the issue of non-compliance with alerts was raised with Southend, albeit verbally. However, CQC went on to give a clean bill of health to the trust on its website.

CONCLUSIONS AND RECOMMENDATIONS:

Since we started researching and reporting on this issue in 2010 there has been massive improvement in the compliance with Patient Safety Alerts. That is very welcome, but we do wonder whether this would be the case without the public scrutiny we have brought to bear.

Even with the improvement, there is no room for complacency. Every alert which is not implemented on time leaves patients at risk of avoidable serious harm or death. It beggars belief that some NHS organisations themselves have allowed this situation to go on for years. It is even more shocking that the regulator, the CQC, has had such a blind-spot with regard to Patient Safety Alerts. Overall, we are impressed with the CQC's new approach to inspection and monitoring. We do appreciate that the new system is still bedding down. However, on this issue they have so far let themselves, the NHS, and patients down. We stressed the need to take alerts more seriously in our **response to CQC's consultation on their new system** here: http://www.avma.org.uk/data/files/RESPONSE_TO_CQC_CONSULTATION_-_FINAL.pdf.

Insofar as the CQC has taken any account of Patient Safety Alerts in its monitoring and inspection of trusts, it appears to have been on the basis of the proportion of alerts which remain outstanding. This is completely illogical. Each alert is mandatory and a life and death issue in its own right. The length of time past the deadline for compliance should also have been taken into account. There can be no excuse for non-compliance being allowed to go on for years.

The CQC seems to have assumed that Patient Safety Alerts were "in abeyance" following the abolition of the NPSA. This was not the case – it simply meant that no new alerts were being issued.

As far as we are aware, the CQC has not been conducting checks on whether alerts which trusts have declared as "completed" have actually been completed satisfactorily/ continue to be completed. When this has been done in the past, a significant number have been found to have been inappropriately declared "completed".

The reforms of the NHS, including the abolition of the NPSA, appear to have been rushed through with little or no thought to transitional arrangements for patient safety. No new patient safety alerts were issued by NPSA after March 2012 until the first alert issued by NHS England in December 2013. Only recently has NHS England announced the launch of its new system of Patient Safety Alerts, and even now there is no joined-up

plan about how compliance will be monitored and regulated. We hope that this report will lead to a more joined-up and robust approach.

Recommendations:

1. The CQC should treat non-compliance with any Patient Safety Alert which is past the deadline for completion much more seriously. The non-compliance should be clearly flagged on its online report on trusts. Using the *proportion* of alerts outstanding is unacceptable and leaves patients at risk.

2. The CQC should require an action plan from trusts who are non-compliant with an alert about how they will comply within a short time-scale. Non-compliance for over six months past the deadline should result in a formal warning notice. Continued non-compliance should result in regulatory action.

3. The Department of Health should take the opportunity in its current consideration of new regulations for the CQC, to underline the mandatory status of Patient Safety Alerts, and to give CQC clear powers to take regulatory action over non-compliance with alerts.

4. The CQC should, as part of its inspection process, audit a sample of alerts which have been declared "completed" to check if they have in fact been completed satisfactorily.

5. NHS England should engage with commissioners, Healthwatch, AvMA and the CQC to ensure that action is taken with regard to non-compliance. We welcome NHS England's plan to publish monthly data on compliance on its website from April 2014.

6. NHS Trusts themselves should report any non-compliance to their public board meetings. Boards should ensure that their trusts comply. Trusts should report on their status with regard to Patient Safety Alerts in their Quality Accounts.

APPENDIX 1

Trusts in alphabetical order, with number of alerts not implemented for each trust

Name of Trust	Number of alerts Not implemented
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	3
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	2
BARNET PCT	1
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	3
BARTS AND THE LONDON NHS TRUST	1
BEDFORD HOSPITAL NHS TRUST	1
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	1
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	2
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	1
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1
CAMBRIDGESHIRE PCT	1
CENTRAL LANCASHIRE PCT	2
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	3
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	4
COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	2
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1
CROYDON HEALTH SERVICES NHS TRUST	2
DERBY HOSPITALS NHS FOUNDATION TRUST	1
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	3
EALING PCT	1
EAST AND NORTH HERTFORDSHIRE PCT	1
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	3
EDEN VALLEY PCT	1
ENFIELD PCT	1
GATESHEAD HEALTH NHS FOUNDATION TRUST	3
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	1
GREAT YARMOUTH AND WAVENEY PCT	1
HARINGEY TEACHING PCT	1
HEART OF ENGLAND NHS FOUNDATION TRUST	2
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	1
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2
KENSINGTON AND CHELSEA PCT	4
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	1
LAMBETH PCT	1
LANGBAURGH PCT	2
LEEDS TEACHING HOSPITALS NHS TRUST	3
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1
LUTON PCT	2
MEDWAY NHS FOUNDATION TRUST	1
MID STAFFORDSHIRE NHS FOUNDATION TRUST	1
NEWHAM UNIVERSITY HOSPITAL NHS TRUST	1
NORTH LANCASHIRE TEACHING PCT	2

NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	1
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	1
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	1
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	1
PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST	1
PRESTON PCT	2
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	3
ROYAL UNITED HOSPITAL BATH NHS TRUST	1
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	2
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	1
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	2
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
SOUTH BIRMINGHAM PCT	1
SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST	1
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1
SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	7
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2
ST GEORGE'S HEALTHCARE NHS TRUST	1
SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST	1
THE DUDLEY GROUP NHS FOUNDATION TRUST	1
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	1
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	2
THE ROYAL WOLVERHAMPTON NHS TRUST	2
THE WHITTINGTON HOSPITAL NHS TRUST	1
TRAFFORD HEALTHCARE NHS TRUST	5
TWO SHIRES AMBULANCE NHS TRUST	3
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	2
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	2
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	1
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	2
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	2
WALSALL HEALTHCARE NHS TRUST	3
WALTHAM FOREST PCT	1
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	1
WEST HERTFORDSHIRE PCT	1
WESTMINSTER PCT	2
WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST	1
WIRRAL PCT	1
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	1

APPENDIX 2

Trusts who have not implemented alerts arranged by number of alerts not implemented (descending order)

Name of Trust1	Number of alerts Not implemented
SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	7
TRAFFORD HEALTHCARE NHS TRUST	5
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	4
KENSINGTON AND CHELSEA PCT	4
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	3
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	3
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	3
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	3
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	3
GATESHEAD HEALTH NHS FOUNDATION TRUST	3
LEEDS TEACHING HOSPITALS NHS TRUST	3
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	3
TWO SHIRES AMBULANCE NHS TRUST	3
WALSALL HEALTHCARE NHS TRUST	3
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	2
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	2
CENTRAL LANCASHIRE PCT	2
COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	2
CROYDON HEALTH SERVICES NHS TRUST	2
HEART OF ENGLAND NHS FOUNDATION TRUST	2
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2
LANGBAURGH PCT	2
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	2
LUTON PCT	2
NORTH LANCASHIRE TEACHING PCT	2
PRESTON PCT	2
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	2
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	2
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	2
THE ROYAL WOLVERHAMPTON NHS TRUST	2
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	2
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	2
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	2
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	2
WESTMINSTER PCT	2
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	1
BARNET PCT	1
BARTS AND THE LONDON NHS TRUST	1
BEDFORD HOSPITAL NHS TRUST	1
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	1
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	1
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1

CAMBRIDGESHIRE PCT	1
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	1
DERBY HOSPITALS NHS FOUNDATION TRUST	1
EALING PCT	1
EAST AND NORTH HERTFORDSHIRE PCT	1
EDEN VALLEY PCT	1
ENFIELD PCT	1
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	1
GREAT YARMOUTH AND WAVENEY PCT	1
HARINGEY TEACHING PCT	1
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	1
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	1
LAMBETH PCT	1
LUTON AND DUNSTABLE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	1
MEDWAY NHS FOUNDATION TRUST	1
MID STAFFORDSHIRE NHS FOUNDATION TRUST	1
NEWHAM UNIVERSITY HOSPITAL NHS TRUST	1
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	1
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST	1
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	1
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	1
PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST	1
ROYAL UNITED HOSPITAL BATH NHS TRUST	1
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	1
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
SOUTH BIRMINGHAM PCT	1
SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST	1
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	1
ST GEORGE'S HEALTHCARE NHS TRUST	1
SUFFOLK MENTAL HEALTH PARTNERSHIP NHS TRUST	1
THE DUDLEY GROUP NHS FOUNDATION TRUST	1
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	1
THE WHITTINGTON HOSPITAL NHS TRUST	1
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	1
WALTHAM FOREST PCT	1
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	1
WEST HERTFORDSHIRE PCT	1
WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST	1
WIRRAL PCT	1
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	1

APPENDIX 3

Southend Hospital
Prittlewell Chase
Westcliff-on-Sea
Essex SS0 0RY

Tel: 01702 435555

Mr Peter Walsh
Chief Executive
Action against Medical Accidents (AvMA)
chiefexec@avma.org.uk

14 January 2014

Dear Mr Walsh

I am writing in respect of your recent enquiry for information held by Southend University Hospital NHS Foundation Trust under the provisions of the Freedom of Information Act 2000. We have now processed your request, please find below our response.

Please supply the following information held created during the period 1st February 2010 – 18th October 2013:

1. *Copies of any internal reports and/or minutes of meetings concerning the Trust's compliance or non compliance with Alerts issued by the National Patient Safety agency*
   Please find enclosed copies of the minutes and reports of the Clinical Assurance Committee (CAC) meetings held during the period 1 February 2008 to 18 October 2013.

2. *Copies of correspondence and/or minutes of meetings between the Trust and any regulator or commissioner of services provided by the trust*
   There are Clinical Quality Review Group (CQRG) meetings held with our Clinical Commissioning Group (CCG). The meetings are chaired by the CCG therefore they may hold the information you require
   http://www.southendccg.nhs.uk/

3. *Details of any incidents identified at the trust where the inadequate implementation of an alert was considered a potential factor*
   There have been no incidents identified.

If you have any further queries or concerns then please do not hesitate to contact us.

Chairman: Alan Tobias OBE
Chief Executive: Jacqueline Totterdell

Further information about your rights is also available from the Information Commissioner at:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire. SK9 5AF
Telephone: 01625 545700
Web Address: www.ico.gov.uk

Yours sincerely

Nicola Frost
Freedom of Information Co-ordinator
Governance Unit

Tel: 01702 435555 Ext 6455
Email nicola.frost@southend.nhs.uk
Visit our website: www.southend.nhs.uk

Chairman: Alan Tobias OBE
Chief Executive: Jacqueline Totterdell

APPENDIX 4

Response issued under the Freedom of Information Act 2000

Our Reference: CQC IAT 2013 1035

Date of Response: 14 November 2013

Information Requested:

"1. Copies of any correspondence, report, or record of meetings or telephone conversations held with management of Southend University Hospitals NHS Foundation Trust with regard to compliance with Patient Safety Alerts by that trust that took place between 1st February 2010 and 18th October 2013.

2. Copies of any internal report or review or board or management meeting on the subject of compliance with patient safety alerts dated between 1st February 2010 and 18th October 2013."

The Information Access team have now processed your request and we can confirm that we have consulted with our colleagues in our Operations directorate.

CQC does not hold any recorded information such as correspondence, reports, records of meetings or telephone conversations between the management of Southend University Hospitals NHS Foundation Trust and CQC, which specifically relates to compliance with patient safety alerts.

CQC does not hold any recorded information such internal reports, reviews or board or management meetings which specifically relate to compliance with patient safety alerts. We have conducted a search of our internal systems and we can confirm there are no reports that specifically relate to compliance with patient safety alerts.

CQC does however hold information relating to the inspections and reviews we conduct but these are not specific to patient safety alerts on their own.

You can access reports for the locations provided by Southend University Hospitals NHS Foundation Trust on our website through:

www.cqc.org.uk/directory/raj

You should note that Southend University Hospitals NHS Foundation Trust is a "registered provider" of care services. The reports we publish relate to "locations".

CQC uses the term "registered provider" to mean the legal entity responsible for carrying on the health or adult social care services we regulate. The legal entity can be one of three types of provider: individuals, partnerships or organisations.

A "location" is a place in which, or from which, regulated activities are provided or managed.

Southend University Hospital and Lighthouse Child Development Centre are registered locations of care for the registered provider, Southend University Hospitals NHS Foundation Trust.

There are reports available for Southend University Hospital for the calendar years 2010, 2011, 2012 and 2013. The most recent report was published in June 2013 and relates to visits in May 2013.

CQC has conducted a follow up inspection on 16 and 17 October 2013. This report is currently at the draft stage and will be published on our website in approximately two weeks' time.

You may also wish to access our Hospital Intelligent Monitoring report for Southend University Hospital NHS Foundation Trust:

www.cqc.org.uk/sites/default/files/media/reports/RAJ_101_WV.pdf

At this stage of our response it may be useful to explain the purpose of the Freedom of Information Act 2000 and the role of CQC with regards to patient safety alerts. CQC is not the lead public for patient safety alerts.

The Freedom of Information Act 2000

It may be helpful to explain the purpose of the Freedom of Information Act 2000 (FOIA). The purpose of FOIA is to ensure transparency and accountability in the public sector. It seeks to achieve this by providing anyone, anywhere in the world, with the right to access any recorded information held by, or on behalf of, a public authority.

FOIA provides a right of access to information not actual documents.

A disclosure under FOIA is described as "applicant blind" meaning that disclosure under FOIA is a disclosure into the public domain not to any one individual.

The role of CQC in the regulation of care services

CQC is the independent regulator of health and social care services in England.

We make sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high-quality care, and we encourage them to make improvements.

We do this by inspecting services and publishing the results on our website to help individuals make better decisions about the care they receive.

CQC is a non-departmental public body (NDPB), overseen by the Department of Health, established under the Health and Social Care Act 2008.

CQC came into existence on 1 October 2008 with the appointment of Board members and a Chief Executive. As a NDPB, the Commission is accountable to the Secretary of State for discharging its functions, duties and powers effectively, efficiently and economically.

CQC became fully operational on 1 April 2009 when it took over the activities of the Commission for Social Care Inspection (CSCI), the Healthcare Commission (HC) and the Mental Health Act Commission (MHAC).

We have published information about who we are, what we do and how we do it, on our website:

www.cqc.org.uk/public/about-us

Monitoring compliance with the essential standards of quality and safety

The role of CQC in the regulation of care services is to determine whether care services are meeting government standards as set out in the relevant legislation.

When running or managing a care service and carrying on a regulated activity there are certain things providers have to do by law. The law also makes certain requirements of CQC, and sets out the powers it has to regulate services.

All of this is contained in certain acts and regulations, which together are referred to as the relevant legislation; the Health and Social Care Act 2008, the Care Quality Commission (Registration) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The legislation is available to view or download from our website:

www.cqc.org.uk/organisations-we-regulate/registered-services/legislation

The Health and Social Care Act 2008 established CQC as the regulator of health and adult social care services. It is a single Act of Parliament that contains our powers and duties.

Regulations are made under powers set out in the Health and Social Care Act 2008, and they provide more detail about the powers and duties CQC has, and about the duties that people providing and managing services have. The regulations made under the main Act change more frequently than the Act itself.

The Care Quality Commission (Registration) Regulations 2009 came into force on 1 April 2010. They apply to all regulated activities, and make requirements about the way that people who wish to provide or manage a regulated activity in England can become registered

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 have come into force at different times according to the type of service involved. They contain definitions of the services and activities that people must be registered to provide. In some cases, they contain details about the stages at which different types of provider will be brought into the registration system. They also contain details of the standards that people registered to provide and manage services will have to observe.

If, at any time, we have concerns that care services are not meeting standards, we can carry out a responsive review.

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.

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"*.

You can view or download a copy of the standards from our website through the following link:

www.cqc.org.uk/organisations-we-regulate/registered-services/guidance-meeting-standards

Alternatively you can order a hard copy through our online ordering system or by calling 03003 230 200.

Information about the online ordering system can be accessed through the following link:

www.cqc.org.uk/public/reports-surveys-and-reviews/order-print-publication

There are 28 essential standards in total, of which 16 relate most directly to the quality and safety of care. These 16 standards are grouped into five key areas.

You may wish to refer to our "Quick guide to the essential standards":

When we inspect we can check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

You can access information on how we inspect, enforce and publish on our website through the following links:

www.cqc.org.uk/organisations-we-regulate/registered-services/how-we-inspect

www.cqc.org.uk/organisations-we-regulate/registered-services/how-we-enforce

www.cqc.org.uk/organisations-we-regulate/registered-services/how-we-publish

Notifications for NHS trusts

Registered persons must notify us about a number of changes, events and incidents affecting their service or the people who use it.

The law requires NHS trusts to use the forms provided by us to submit notifications not made through the National Reporting and Learning System (NRLS) within certain timescales.

To avoid duplication of reporting, the regulations allow NHS trusts to submit most notifications about 'serious and untoward incidents' affecting people who use their services to the NRLS.

The NRLS is the reporting and learning system previously provided by the National Patient Safety Agency (NPSA). It is now provided by the Imperial College NHS Trust under contract to the NHS Commissioning Body.

Notifications submitted to the NRLS through a local risk management system (LRMS) are then forwarded on to CQC. Recent analysis of these notifications shows that CQC has received 35. Of these 35 notifications these relate to a range of matters such as serious incidents and safeguarding incidents. They do not solely relate to patient safety alerts.

Further information about notifications is available on our website:

www.cqc.org.uk/organisations-we-regulate/registered-services/notifications/notifications-nhs-trusts

NRLS

The National Reporting and Learning System (NRLS) was established in 2003.

The system enables patient safety incident reports to be submitted to a national database.

From 1 April 2010 it became mandatory for NHS trusts in England to report all serious patient safety incidents.

CQC only receives notifications rated 'severe', 'moderate', 'death' or 'abuse'.

The data has a delay. Incidents recently reported may not appear in this analysis.

Patient Safety Alerts

The public authority responsible for patient safety alerts is the National Patient Safety Agency (NPSA). NPSA is an arm's length body of the Department of Health. It was established in 2001 with a mandate to identify patient safety issues and find appropriate solutions.

Further information is available on the website for the NHS Commissioning Board Special Health Authority:

www.nrls.npsa.nhs.uk/resources/type/alerts/

The contact details for making a request to this authority are:

E-mail: commissioningboard@nhs.net
Website: www.npsa.nhs.uk/corporate/about-us/foi/

Independent advice about information legislation

If you need any independent advice about your rights under information legislation, you can contact the Information Commissioner's Office (ICO).

The ICO is the UK's independent authority set up to uphold information rights in the public interest, promoting openness by public bodies and data privacy for individuals.

The contact details for the ICO are:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
SK9 5AF

Tel: 01625 545 745
E-mail: casework@ico.org.uk
Website: www.ico.org.uk

There is useful information on the ICO website explaining how you can access official information:

www.ico.org.uk/for_the_public/official_information

You may also wish to consider (if you have not already done so) making a request for information directly to Southend University Hospitals NHS Foundation Trust.

The contact details are:

Mrs Nicola Frost
Freedom of Information Co-ordinator
Service Reliability and Safety Department
Southend University Hospital NHS Foundation Trust
Prittlewell Chase
Westcliff on Sea
Essex
SS0 0RY

Tel: 01702 435 555 extension 6455
Fax: 01702 221 079
E-mail: nicola.frost@southend.nhs.uk
Website: www.southend.nhs.uk/about-us/freedom-of-information-(foi)/

CQC Complaints and Internal Review procedure:

If you are not satisfied with our handling of your request, then you may request an internal review.

Please clearly indicate that you wish for a review to be conducted and state the reason(s) for requesting the review. To request a review please contact:

Legal Services & Information Rights
Care Quality Commission

Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

E-mail: information.access@cqc.org.uk

Please be aware that the review process will focus upon our handling of your request and whether CQC have complied with the requirements of the Freedom of Information Act 2000. The internal review process should not be used to raise concerns about the provision of care or the internal processes of other CQC functions.

If you are unhappy with other aspects of the CQC's actions, or of the actions of registered providers, please see our website for information on how to raise a concern or complaint:

www.cqc.org.uk/contact-us

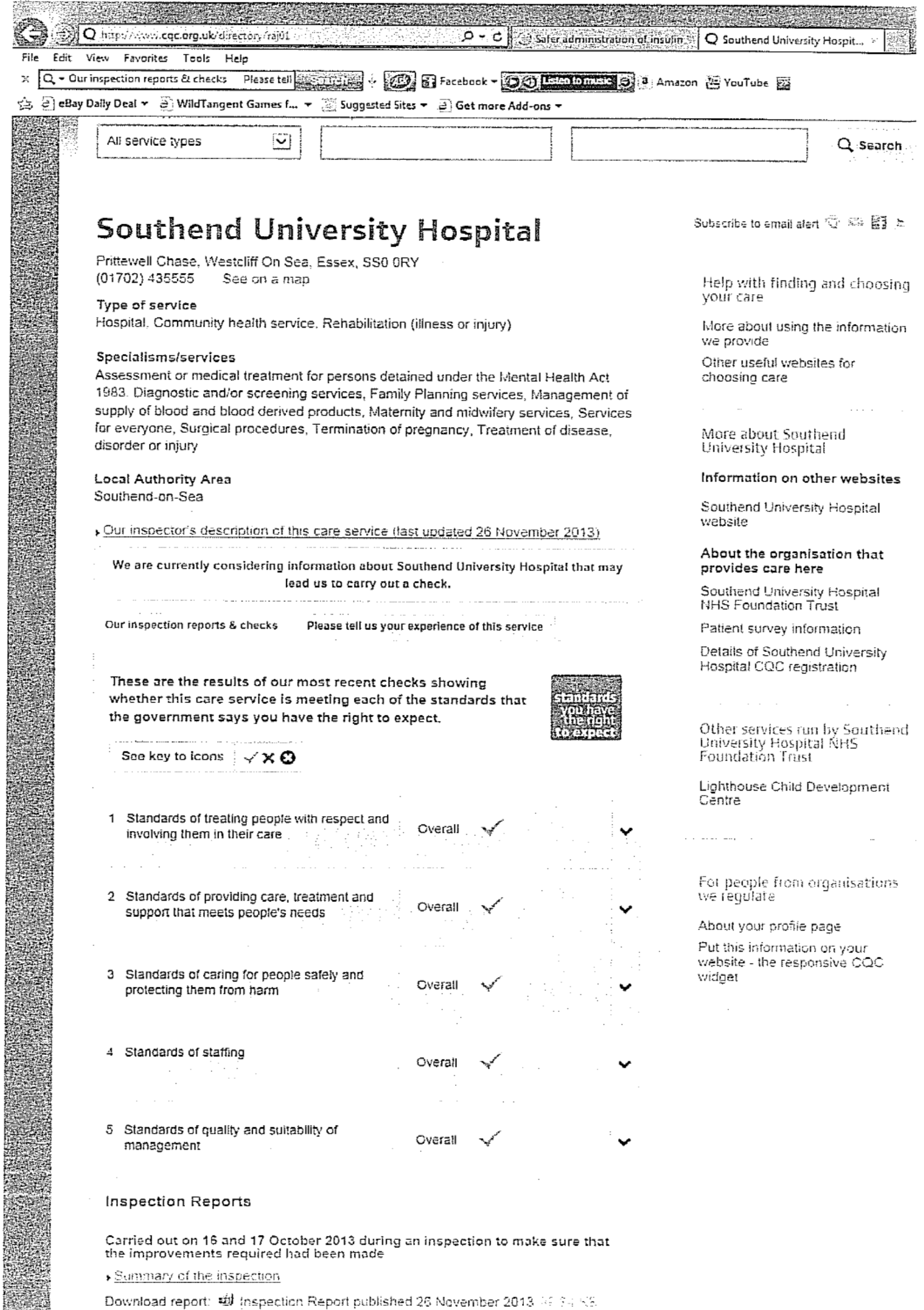
Further rights of appeal exist to the Information Commissioner's Office under section 50 of the Freedom of Information Act 2000 once the internal review process has been exhausted.

The contact details are:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
SK9 5AF

Telephone: 01625 545 745
Website: www.ico.org.uk

APPENDIX 5



https://www.cqc.org.uk/directory/raj01 | Safer administration of insulin | Southend University Hospit...
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All service types Search

Southend University Hospital

Subscribe to email alert

Prittewell Chase, Westcliff On Sea, Essex, SS0 0RY
(01702) 435555 See on a map

Type of service
Hospital, Community health service, Rehabilitation (illness or injury)

Specialisms/services
Assessment or medical treatment for persons detained under the Mental Health Act 1983, Diagnostic and/or screening services, Family Planning services, Management of supply of blood and blood derived products, Maternity and midwifery services, Services for everyone, Surgical procedures, Termination of pregnancy, Treatment of disease, disorder or injury

Local Authority Area
Southend-on-Sea

Our inspector's description of this care service (last updated 26 November 2013)

We are currently considering information about Southend University Hospital that may lead us to carry out a check.

Our inspection reports & checks | Please tell us your experience of this service

These are the results of our most recent checks showing whether this care service is meeting each of the standards that the government says you have the right to expect.

standards you have the right to expect

See key to icons ✓ ✗ ⊗

	Standard		
1	Standards of treating people with respect and involving them in their care	Overall	✓
2	Standards of providing care, treatment and support that meets people's needs	Overall	✓
3	Standards of caring for people safely and protecting them from harm	Overall	✓
4	Standards of staffing	Overall	✓
5	Standards of quality and suitability of management	Overall	✓

Inspection Reports

Carried out on 16 and 17 October 2013 during an inspection to make sure that the improvements required had been made

Summary of the inspection

Download report: Inspection Report published 26 November 2013

Help with finding and choosing your care

More about using the information we provide

Other useful websites for choosing care

More about Southend University Hospital

Information on other websites

Southend University Hospital website

About the organisation that provides care here

Southend University Hospital NHS Foundation Trust

Patient survey information

Details of Southend University Hospital CQC registration

Other services run by Southend University Hospital NHS Foundation Trust

Lighthouse Child Development Centre

For people from organisations we regulate

About your profile page

Put this information on your website - the responsive CQC widget