UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 26 JANUARY 2017

Title:	**QUARTER 3 COMPLIANCE AND ASSURANCE REPORT**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Louisa Sorrell, Senior Manager Clinical Compliance

Purpose:	To provide the Board of Directors with information regarding internal and external compliance as of 31 December 2016.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	• The new clinical compliance framework is being rolled out across all specialities (except Div A, as the measures need to be updated to be applicable to the specialities in that division). • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 77% of cases (79% in Q2). • There were 14 external visits in quarter 3. • Compliance for quarterly review of risk registers is 100%	
Recommendations:	The Board of Directors is asked to accept the report.	
Approved by:	D Burbridge	Date: 17 January 2016

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 26 JANUARY 2017

QUARTER 3 COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY DIRECTOR OF CORPORATE AFFAIRS

1. Purpose

1.1 The purpose of this paper is to provide the Board of Directors with information regarding internal and external compliance as of 31 December 2016.

2. Trust Compliance with Regulatory Requirements

2.1 Care Quality Commission (CQC)

2.1.1 The Trust is governed by several regulatory requirements and the Risk and Compliance Unit currently has specific oversight of the CQC requirements.

2.1.2 Announced Inspection

The CQC carried out an announced inspection of the Trust in January 2015 and published its findings in May 2015. The Trust was assessed as being fully compliant with the CQC essential standards. However, the CQC did highlight some areas of weakness and these have formed part of an action plan which is monitored by the Director of Corporate Affairs Governance Group. There is 1 action which has not been fully implemented; details of the action plan are contained within Appendix A.

2.1.3 Focused Inspection

a) The CQC carried out a focused inspection relating to cardiac surgery on 21 and 22 December 2015. The visit was triggered by the release of data in September 2015 by the National Institute for Cardiovascular Outcomes Research, suggesting that the Trust was an outlier in terms of mortality. During September 2015, the Trust had established, before any notification from the CQC, a Cardiac Surgical Quality Improvement Program (CSQIP).

(b) Following the inspection, the CQC placed 2 conditions on the Trust's registration with the CQC, which were subsequently removed on 25 May 2016.

(c) The Trust continues to provide a quarterly report to the CQC and NHS England, which includes an update on progress against the CQC's and external reviewer's recommendations. The report also includes a quarterly analysis of the clinical outcome data. At the time of writing this report, only 1 out of 62 actions remain outstanding and this continues to be monitored by the CSQIP steering group.

2.1.4 CQC Correspondence

The table below provides a summary of data or queries raised by the CQC during Q3.

Date of request or contact	Division	Request or contact description	Findings of investigation & CQC response
26/10/2016	C	WB ENQ1-3014392614 - A member of staff on a ward raised concerns regarding: staffing, new discharge process, manipulation of staffing dashboard, bullying in the workplace.	Staffing: The staffing data for the period of 5th September to 24th October 2016 shows that there was a small number (five or less) of shifts where the staff/patient ratio was reported as being at the minimum threshold. On these shifts, action was taken to provide additional support to the ward, for example, temporary staffing (bank or agency staff) was utilised to cover an early shift. Discharge: The new discharge process is linked to Trust initiatives around improving the flow around discharge and the utilisation of the discharge lounge, which includes earlier on the day discharge to enable beds to be freed up for emergency and elective patients. The new process has proven to be successful with positive feedback from patients being received. Manipulation of staffing dashboard: After triangulation of the dashboard with the ward's allocation sheets, a small number (five or less) of occasions were found (between 5th September – 24th October 2016) where the dashboard did not fully

			match the ward allocation sheets. We have learnt that the divisional management team's focus has been to ensure that the allocation sheets within the ward are fully accurate, which on these occasions resulted in the staffing dashboard not being updated. <u>Bullying in the workplace:</u> It was suggested that the individual who made contact with CQC is advised to refer to the Trust,s 'Prevention of Harassment and Bullying at Work' policy and procedure or to refer any concern to the Human Resources Department, so that any concern can be investigated accordingly. There was no evidence of bullying found.
26/10/2016	C	ENQ1-3008206517 - Formal complaint from a patient relating to a drug omission	We carried out a Trust wide search for any incidents that related to the drug in question being missed for the stated time frame, however, nothing was found. We also carried out a further search for any patient prescribed that drug during that period, however, no record was found. There was, therefore, no evidence that the drug was omitted.

2.1.5 <u>Clinical Compliance Framework</u>

(a) As advised in the quarter 1 report, the existing compliance framework was reviewed in light of the recent CQC inspection into cardiac surgery and was amended to include speciality focused measures.

(b) The quarter 2 report provided a summary of the new framework and the outcome of the pilot. During quarter 3 and 4 the compliance framework is being rolled out across all specialities within the Trust (with the exception of Division A as the measures need to be updated to be applicable to the specialities in that division).

(c) Details of the compliance scoring will be presented in future BoD reports once the framework has been implemented across all specialities. In the interim, compliance for each speciality will be monitored by the divisional management teams via the speciality

meetings.

2.2 NICE

2.2.1 The Trust either meets all recommendations, or is working towards meeting all recommendations, in 77% of cases. In 10% of cases, the guidance is under review by a senior clinician. In 12% of cases, the Risk and Compliance Unit are awaiting a response from the Guidance Lead. In 1% of cases, there is a divergence against NICE recommendations.

2.2.2 Overdue responses are highlighted at Specialty meetings and the Divisional Clinical Quality Group (DCQG) meetings. The Divisional follow-up follow up all overdue responses with the individuals.

Figure 1: Breakdown of non- compliance with NICE guidance by Division

Non-Compliant	Partially Compliant	Overdue Response	Under Review/Working towards compliance
Division A			
0	**2**	**3**	**11**
Division B			
3 in total: **2 -** Not Compliant and approved **1 -** Awaiting decision from the Divisional Director followed by CQMG-Email sent.	**0**	**9**	**16**
Division C			
1 – Divergence Approved by CQMG	**1**	**9**	**28**
Division D			
0	**0**	**8**	**32**

Trust Compliance with External Visits/Peer Reviews

2.3 The Trust has a process in place to ensure the appropriate coordination and evaluations of external recommendations arising from external agency visits, inspections, accreditations and peer review/assessment.

2.4 The table below contains full details of the outcome of the visits that took place in Q3 2016/17. It also includes details of external visits that took place in previous quarters of which the outcome of the visits were unknown at the time of reporting.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
UKAS (United Kingdom Accreditation Service)	Cellular Pathology	A	11th Oct 2016	The inspectors found that the documents supplied may have been adequate under CPA standards but were not in sufficient depth and breadth to meet the ISO 15189 standards. Laboratory Management has withdrawn their application for CPA/UKAS accreditation for the scope of the Cellular Pathology Laboratory.	Negative	Awaiting action plan.
UKAS (United Kingdom Accreditation Service)	Microbiology	A	11th Oct 2016	12 findings requiring mandatory actions, all have now been actioned and action plan was sent to UKAS.	Positive	
HTA - Human Tissue Authority	Tissue Services	A	7th-8th Dec 2016	Feedback on the day was overall positive but currently awaiting final report.	TBC	Awaiting report.
B.S.I. - British Standards Institution	Radiation Protection Services (RRPPS)	A	24th Nov 2016	A minor nonconformity requiring attention was identified regarding the purchasing system. This has now been actioned and B.S.I has issued a new certificate.	Positive	
MHRA - Medicines and Healthcare Products Regulatory Agency	Radio-pharmacy	A	30th Nov-1st Dec 2016	The purpose of the inspection was the first licence inspection. The MHRA found 3 majors and 12 others.	Neutral	Awaiting report and action plan
Royal College of Surgeons	Cardiac Surgical Services	A/B	1st-3rd Nov 2016	Verbal feedback provided – following identified as requiring further work: o Efficiency and effectiveness o Theatre staff bottle-neck o Future strategy for the service and how this will be achieved. They said it will take time to get where we want to be. Report in 6-8 weeks.	TBC	Awaiting report.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
Department of Health - Vascular Clinical Quality & Efficiency Programme	Vascular Surgery	B	21st June 2016	Overall positive findings and this was a pilot visit. A number of recommendations were made and an action plan is being developed to implement advised improvements.	Neutral	Awaiting action plan.
NHS England Quality Surveillance Team (QST) - Peer Review Programme	Heart and Lung Transplant	B	1st June 2016	National Peer Review published. UHB compliant with 57% of measures. Awaiting local report – TBC in Q4 2016/17 report.	TBC	Awaiting report.
CCG - Clinical Commissioning Group	Renal Medicine	B	13th July 2016	Unannounced visit to ward 303. Overall the verbal feedback was very positive. Awaiting report – TBC in Q4 2016/17 report.	TBC	Awaiting report.
CCG - Clinical Commissioning Group	Liver, Upper GI and Colorectal	B	21st July 2016	Unannounced visit to wards 727 & 728. Awaiting report – TBC in Q4 2016/17 report.	TBC	Awaiting report.
NHS England Quality Surveillance Team (QST) - Peer Review Programme	Renal Services	B	8th Dec 2016	3 areas of serious concern (definition of a "serious concern" is an issue that, whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve). 1. There are insufficient numbers of consultant transplant surgeons to deliver a sustainable transplant programme. This could have a detrimental impact on the health and well-being of the surgical team and/or can cause delays in the patient pathway therefore adversely impacting on the quality of patient care and outcomes.	Neutral	Trust's plan and actions to address the serious concern by 19th January 2017.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
				2. The lack of theatre capacity with expertise to facilitate a sequential kidney transplant operation for adult patients within a 24 hour period is currently not available which could have an adverse impact on the co-ordination and efficiency in performing the transplant procedure and therefore could have significant consequences on care delivery and patient outcomes. 3. The overall quoracy at the listing MDT meeting is less than 67%, and as a consequence, there is no assurance that all patients benefit from the knowledge and expertise of a full multi-disciplinary discussion which could potential impact on patient outcomes.		
NHS England Quality Surveillance Team (QST) - Peer Review Programme	Liver Transplant	B	7th Dec 2016	3 areas of serious concern (definition of a "serious concern" is an issue that, whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve). 1. The lack of theatre capacity with expertise to facilitate a sequential liver transplant operation for adult patients within a 24 hour period is currently not available which could have an adverse impact on the co-ordination and efficiency in performing	Neutral	Trust's plan and actions to address the serious concern by 19th January 2017.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
				the transplant procedure and therefore could have significant consequences on care delivery and patient outcomes. 2. The on-call service for the recipient co-ordinators is provided by co-ordinators in substantive posts. There are a number of co-ordinator posts vacant, therefore the expected number of on-calls per co-ordinator is increased and this has an impact on the routine day work that needs to be carried out as staffing levels are reduced due to being on-call. 3. The overall quoracy at the listing MDT meeting is less than 67%, and as a consequence, there is no assurance that all patients benefit from the knowledge and expertise of a full multi-disciplinary discussion which could potential impact on patient outcomes.		
CCG	W518 Multi Specialty Medicine (Older Adult)	C	17th Oct 2016	There were some areas identified during the visit which need attention such as a continued focus on equipment cleaning and infection prevention practices.	Positive	All actions that were identified have now been rectified.
CCG	Medicine Wards (Safeguarding)	C	21st Oct 2016	There were no specific requirements or recommendations arising out of the visit other than three points for consideration: 1. "This is me" - could be utilised better. 2. Potential for discussion of safeguarding/mental	Positive	N/A

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
				capacity issues to be built into handovers to embed learning and understanding. 3. Care plans specifically detailing DOLs for patients would be beneficial, with 'Dos and Dont's' and spelling out what 'least restrictive practise' looks like.		
CCG	A&E and CDU	C	5th Dec 2016	Unannounced visit to ED - Emphasis on quality, safety and patient experience. Verbal feedback has been positive with no immediate concerns raised and no remedial actions to be taken. They were complimentary about the OPAL service and the way in which we manage privacy and dignity for patients on the corridor.	TBC	Awaiting report.
NSHCS accreditation visit for STP training in Neurophysiology	Neurophysiology	D	22nd June 2016	Accredited with conditions - to be actioned by 28/10/2016: 1. The panel recommend the department reflect on Patient and Public Involvement in order to ensure Patient Centred Care plays an important part in of the training given 2. The panel recommend that competencies and assessments are more focused, to reduce the volume of evidence provided and thus reduce the burden on both trainee and assessor.	Neutral	Following the accreditation report we were required to submit a training plan incorporating the recommendations. This has been submitted and we await confirmation that it meets the requirements.
Department of Health - Vascular Clinical Quality & Efficiency Programme -	Neurosurgery	D	16th Nov 2016	Informed that the initial feedback is positive and a full report is will be sent to the Trust shortly.	TBC	Awaiting report.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
Getting It Right First Time (GIRFT)						
Birmingham Central Foundation School / HEE WM	Education	Corporate	22nd Nov 2016	2 potential patient safety issues were found, only (1 of which related to UHB: 1. Potential delays in administration of intravenous fluids and antibiotics due to a shortage of trained nursing staff in haematology/oncology on duty.	Neutral	Awaiting investigation and, if appropriate, action plan.
DGSA (Dangerous Good Safety Audit)	Health and Safety	Corporate	21st Dec 2016	As a result of this assessment, the Trust was found to be, other than an ongoing need for some basic dangerous goods training for some staff, to be complying fully with these requirements.	Positive	N/A
NHS England Quality Surveillance Team (QST) - Peer Review Programme	Cancer Services	Corporate (D)	5th May 2016	3 Serious concerns raised from each review(definition of a "serious concern" is an issue that, whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve). Head & Neck: - Lack of core Dental practitioner at MDT. - Lack of dietetic resource for MDT. - Low MDT attendance. CUP: -Recruitment of consultant clinical oncologist. - MDT attendance - Audit for inpatients - Audit for outpatients	Neutral	Outstanding action: - Business case - MDT attendance (CUP). Business case has been delayed as we are assessing the service requirements to meet the new Enhanced Supportive Care CQUIN. Aiming at Q4 CEAG for submission. - Audit for inpatients (24 hrs). and outpatients (14 days).

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
						Due to gaps in the AOS/CUP CNS team the audit is still outstanding. This is due to maternity leave and long term sick. Aim to complete the audit by Feb 17.

3. Outcome of Audits

3.1 National Audits:

3.1.1 The Trust is currently either participating in, or scheduled to participate in, 32/34 National Audits listed on the HQIP Quality Accounts. There are two audits currently not participated in by the Trust:

(a) The National Cardiac Arrest Audit – long standing agreement to not participate from Medical Director due to concerns over the methodology of the audit.

(b) National Diabetes Audit – Currently not possible to fully participate due to extensive resource requirement to do so. This is under review as part of ongoing work on national audit.

3.2 Local Audits:

3.2.1 The table below provides an overview of the number of local audits registered on the Trust's Clinical Audit Registration & Management System (CARMS) within quarter 3. Figure 3 shows these figures compared to the previous quarter.

Figure 2: Q3 16/17 Audit Activity

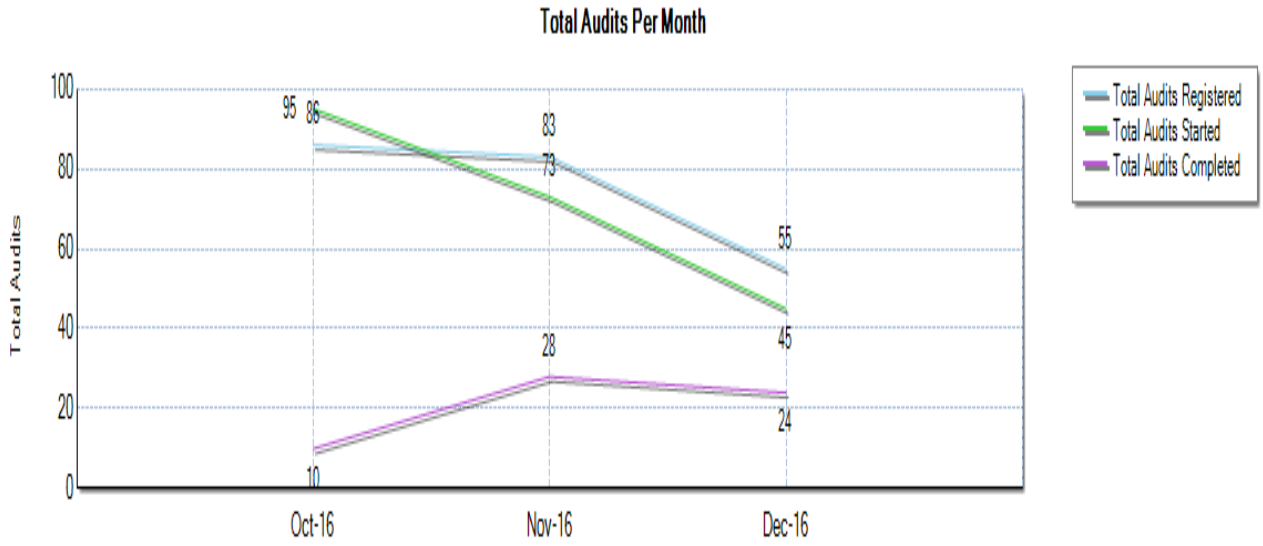

Figure 3: Comparison of audit activity with previous quarters

Quarter	Month	Total Audits Registered	Total Audits Started	Total Audits Completed
1	April	48	55	18
	May	61	46	22
	June	71	65	20
2	July	56	46	15
	August	54	45	26
	September	81	72	15
3	October	86	95	10
	November	83	73	28
	December	55	45	24

4. Risk Register Audit

4.1.1 Compliance for quarterly review of risk registers is as follows:

Target	Q1	Q2	Q3	Q4
95%	95.6%	96.8%	100%	-

4.1.2 In the quarter 2 report compliance was reported as being 91.4%, following subsequent updates and evidence received, the compliance for quarter 2 was actually 96.8%.

4.1.3 Where there is no evidence that high and significant risks have been reviewed, the Risk and Compliance Unit will liaise with the relevant management teams to ensure a quarterly review.

4.1.4 The audit will be repeated for Quarter 4, 2016-17 to ensure continued monitoring of compliance with the risk register process.

5. Recommendation

The Board of Directors is asked to accept this report.

David Burbridge **January 2017**
Director of Corporate Affairs