UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 27 JULY 2017

Title:	**QUARTER 1 COMPLIANCE REPORT**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Louisa Sorrell, Head of Clinical Risk and Compliance Stacey Goodwin, Senior Manager Clinical Compliance

Purpose:	To provide the Board of Directors with information regarding internal and external compliance as of 30 June 2017.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	• There were 2 queries raised by the CQC in Q1 • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 84% of cases (79% in Q4) • There were 4 external visits in Q1 • Compliance for quarterly review of risk registers is 98%	
Recommendations:	The Board of Directors is asked to accept the report.	
Approved by:	D Burbridge	Date: July 2017

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 27 JULY 2017

QUARTER 1 COMPLIANCE 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 30 June 2017.

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 After the completion of all comprehensive inspections of NHS Trusts the CQC have recently been in consultation on their next phase of regulation. Consequently they have updated their inspection methodology and key lines of enquiries. The CQC are aiming for the first regulatory planning meetings to take place from August 2017, the first next phase inspections will take place between September and November 2017, and the first next phase ratings and inspection reports will be published in early 2018.

2.1.3 Section 2.1 of this report details outcomes from any inspections during quarter 1 and an update on any outcomes form existing inspections.

2.1.4 CQC Inspections

(a) Cardiac Surgery Service

The CQC carried out a focused inspection relating to cardiac surgery on 21 and 22 December 2015. Following the inspection, the CQC placed 2 conditions on the Trust's registration with the CQC, which were subsequently removed on 25 May 2016. NHS England has now taken over the oversight of this from the CQC and the Trust is currently in discussions with them to determine how they will be monitoring progress going forward.

(b) Assure Dialysis Unit, Smethwick

On 5th June 2017 the CQC carried out an announced inspection on the unti. A follow-up unannounced inspection was then carried out on 15th June 2017 along with an additional data request. All data requests have now been actioned and submitted to the CQC and the Trust now awaits the draft report.

(c) Diaverum Dialysis Unit, Aston

On 11 July the Trust was informed that concerns had been raised regarding the quality of care being delivered at the Aston Cross Unit which is run by Diaverum (the Trust commission's dialysis care at this unit for its patients). This was following their announced inspection on the 28 June and an unannounced visit on 3 July. The Trust was advised of the CQCs intention to issue a Notice of Proposal to vary a condition on Diaverum's registration. The CQC have advised the Trust that they have not identified any harm to patients.

On 13 July senior clinical and operational representatives from UHB and Diaverum met and following the meeting Diaverum have confirmed the following actions:

- Issues identified by the CQC team have been fed back to staff at 'all' staff meeting Friday 14 July
- Investigation / review team has been identified. The remit of this group is to establish root cause of the issues identified within the report. Terms of reference have been developed and sent to the Trust for review and comment. A peer review of the Aston Clinic will be carried out between 17 and 21 July with a report submitted to Diaverum Executive team on Friday 21 July.
- A Turnaround Team has been identified. The remit of this team is to ensure the standards of care in the Aston unit are meeting National, Organisational (Diaverum) and UHB standards. The Team will develop and deliver an action plan. Terms of reference have been developed and received by UHB for review and comment. The Turnaround team will be starting on Monday 17 July and their involvement in the clinic is expected to last for a number of months. UHB has been invited to include a representative on this team. Additional expert advice will also be provided by UHB e.g. Infection Control.

The Trust will continue to have its monthly, contract review meeting which involves senior clinical and operational managers from both organisations. At this meeting the monitoring template is reviewed, which includes KPI's set out within the contract. Additional time will also be allocated to discuss the improvement programme at Aston.

With regards business continuity plan, the Trust has a business continuity plan in place for service interruption.

2.1.5 <u>CQC Correspondence</u>

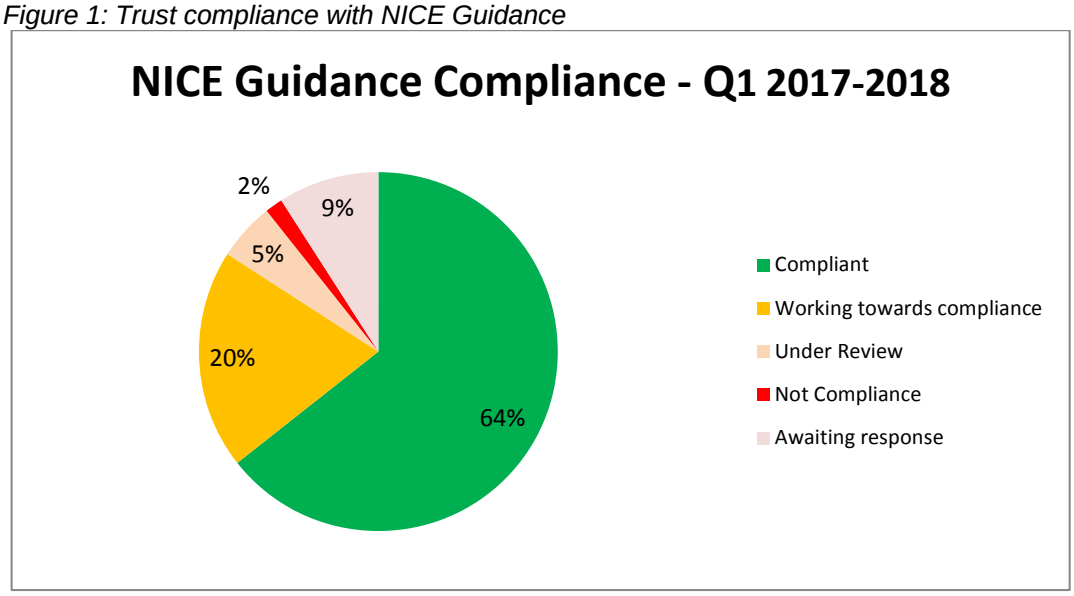
There were 2 complaints/queries raised by the CQC during Q1. CQC have advised that they are happy with the response and action taken by UHB. Details of these are in Appendix A.

3. NICE

3.1. The graph below shows the current compliance levels for NICE guidance. The Trust either meets all recommendations, or is working towards meeting all recommendations, in 84% of cases (79% in the previous quarter). This is the highest rate of compliance achieved for the

Trust since Clinical Compliance has been reporting on NICE.

Figure 1: Trust compliance with NICE Guidance



4. Trust Compliance with External Visits/Peer Reviews

4.1. There were **4** external visits during Q1. There were **4** visits from previous quarters where the outcomes were unknown at the time of reporting. The current status of the visits are as follows:

4.1.1. Positive assurance (no concerns/risks were found or all actions have been completed and evidenced) – **2** visits

4.1.2. Neutral assurance (concerns/risks were found and an action plan has been received by Risk and Compliance to address all shortfalls) – **4** visits

4.1.3. Negative assurance (major failings were found during the visit or identified actions are overdue) – **0** visit

4.1.4. Reports have not been received for **2** visits and details of these visits will be included in the quarter 2 2017/18 report.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
CCG - Clinical Commissioning Group	Renal Medicine Liver, Upper GI and Colorectal	B	13th July 2016 21st July 2016	Unannounced visits to wards 303, 727 and 728. Overall the verbal feedback was very positive with no immediate concerns. 2 recommendations were made: 1. Ensure all staff	Positive	1. All staff have now repeated their tissue viability competencies. 2. A Registered nurse participates in each meal service to ensure all patients are fed. The Practise Development Team will continue to

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
				are aware of the need to complete skin checks for patients who are wearing TED stockings. 2. Meal time processes to be reviewed, ward staff need to be assured that all patients have been given meals, and that where meals are refused that nurses are aware of this, and nutritional plans can be developed if needed.		monitor this via the Nutrition and Hydration Audits.
B.S.I. - British Standards Institution	Oncology	D	14th – 15th March 2017	There were 5 minor non-conformities (NC) identified: 1. Not all records for ward patients were available or complete 2. The organisation in Medical Physics has not conducted internal audits at planned intervals to check quality management system 3. The organisation has not defined all of the necessary controlled conditions as applicable, e.g. a) the availability of information that describes the characteristics of the product 4. The central records of competence (Q Pulse) were not up to date and	Neutral	3/5 NCs have now been rectified. 2 are ongoing, awaiting audits – planned action date of October 2017. The service was recommended for continued accredited certification. The service also meets 89% of the new standard and have been given a completion date on full registration to ISO9001:2015 (new standard) of March 2018.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
				reflective of staff individual files or latest PDRS. 5. Forms are not completed or retained as defined as records of treatment.		
UKAS (United Kingdom Accreditation Service)	Biochemistry	A	15th – 16th March 2017	Awaiting action plan – TBC in Q2 2017/18 report.	TBC	Awaiting action plan – TBC in Q2 2017/18 report.
UKAS (United Kingdom Accreditation Service)	Haematology	A	27th March 2017	This was a remote surveillance visit as part of the accreditation cycle. 31 non-conformities and 3 areas for improvement were identified.	Neutral	All non-conformities raised have now been closed off pending the Decision Maker's response.
JACIE - Joint Accreditation Committee ISCT (International Society for Cellular Therapy) EBMT (European Society for Blood and Marrow Transplantation)	Haematology	D	3rd-4th April 2017	The inspectors highlighted many positive elements of the service including committed, professional and skilled staff who are enthusiastic about their unit and performed their job with necessary expertise and teamwork. Areas of concern were raised largely in Cellular Therapy Product Administration & Clinical Facilities and Quality Management predominantly around the Quality Manual and staffing levels.	Neutral	The service is addressing all areas of concern/improvements raised and is required to submit a response by 28th December 2017. Risk and Compliance will be supporting them during this process.
Clinical Commissioning Group (CCG)	Emergency Department	C	31st May 2017	The CCG carried out an unannounced visit to ED that focused	Positive	All 4 issues raised have been addressed and assurance has been

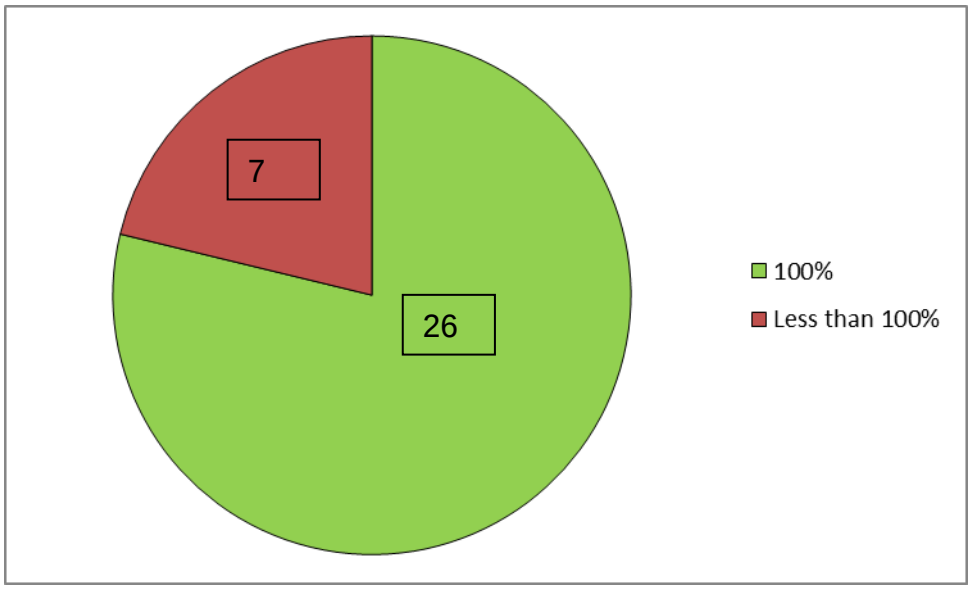
Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
				on Patient Experience and Safeguarding. The outcome was positive with no immediate risks identified. 4 minor issues were raised: 1. Is the use of trolleys to manage capacity in ED on the local risk register and how is it mitigated? 2. How is safeguarding flagged in ED and information shared when patients are transferred? 3. Children in play area are not visible to staff. 4. Toilet doors could be utilised to display important local telephone numbers.		provided to the CCG.
UKAS (United Kingdom Accreditation Service)	Molecular Pathology	A	13th – 14th June 2017	There were 23 non-conformances raised, and 1 recommendation.	Neutral	This was an initial application visit therefore the service has 12 weeks to demonstrate that they have corrected the issues raised. Evidence to be submitted to UKAS by 6th September 2017. A plan has been put into place for the clearance of the NC's and this is monitored and reviewed within the department and Clinical Compliance.
HTA - Human Tissue Authority	Organ Transplantation (Heart, Liver, Renal)	B	20th – 22nd June 2017	Awaiting report – TBC in Q2 2017/18 report	TBC	Awaiting report – TBC in Q2 2017/18 report

4.2. Quality Surveillance Programme

4.2.1. The National Quality Surveillance Programme (formerly National Peer Review Programme) led an Integrated Quality Assurance Programme for NHS England. This programme requires specialised services and all of cancer services to complete a self-declaration on their Quality Surveillance Information System (QSIS).

4.2.2. The self-declarations are completed by the clinical lead within the specialty and subsequently approved by the Divisional Management Team before being signed off by the Chief operating Officer. The risk and compliance team facilitate this process and place any risks identified through the self-declaration process on the relevant risk register to be monitored.

4.2.3. The chart below provides the overall number that achieved100% compliance based on their self-assessment for 2016/17.



5. Outcome of Audits

5.1. National Audits:

5.1.1. The Trust is currently either participating in, or scheduled to participate in, 32/35 National Audits listed on the HQIP Quality Accounts during 2017/18. There are 2 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.

Of these 35 mandatory National Audits listed on the Quality Accounts, 1 is new for 2017/18;National Audit of Breast Cancer in Older Patients, which collects data as part of the pre-existing Cancer Outcomes and Services Dataset (COSD).

5.2. Local Audits:

The table below provides an overview of the number of local audits registered on the Trust's Clinical Audit Registration & Management System (CARMS) within the last 12months.

Quarter	Month	Total Audits Registered	Total Audits Started	Total Audits Completed
1 – 2017/18	April	42	38	12
	May	67	64	16
	June	52	43	18
4 – 2016/17	January	76	79	37
	February	68	53	29
	March	70	60	11
3 – 2016/17	October	86	95	10
	November	83	73	28
	December	55	45	24
2 - 2016/17	July	56	46	15
	August	54	45	26
	September	81	72	15

6. Risk Register Audit

6.1. Internal Audit carried out an audit on the Trusts Board Assurance Framework and Risk Management process and provided 'significant assurance with minor improvement opportunities'.

6.2. Compliance for quarterly review of risk registers is as follows:

Target	Q1	Q2	Q3	Q4
95%	98%			

7. Recommendation

The Board of Directors is asked to accept this report.

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

Appendix A: Queries raised by the CQC

The table below provides details of any queries raised by the CQC during Q1 including any complete, ongoing or outstanding actions.

Date of request or contact	Division	Request or contact description	Findings of investigation & CQC response
07/06/2017	B	Through working with the Royal College of Surgeons CQC had been made aware that UHB had not submitted complete data for one of the measures for the National Bowel Cancer Audit programme (90 day mortality and 30 day readmission).	The two data items quoted are not part of the dataset we submit as a Trust and based on the audit guidance appear to be something the national team retrieve from HES data. Patient data was only submitted shortly before CQCs query was received so it is assumed that the lack of patients to link to is why this data was not available. All data has now been submitted. The Trust has now employed a full time member of staff to look after UHBs data entry for the national bowel and oesophago-gastric cancer audits. Moving forward the data is being inputted prospectively into Somerset which should allow us to complete data in a more timely fashion in the future, in addition to improving our data quality.
15/06/2017	B	The CQC received an anonymous complaint regarding the care provided on ward 305 and in particular the development of a pressure ulcer. The Trust were requested to send them information about the number of pressure ulcers reported as developing on ward 305 on a month by month basis over the last year.	There were two Grade 2 device-related pressure ulcers reported during this period (one from oxygen tubing and one from a urinary catheter). A Grade 4 pressure ulcer was also reported in April 2017 (the Trust reported zero Grade 4 hospital acquired pressure ulcers over the previous year). This pressure ulcer is currently being investigated via the root cause analysis process and will be forwarded to the CQC once complete.