UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 22 OCTOBER 2015

Title:	**QUARTER 2 COMPLIANCE AND ASSURANCE REPORT**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Bob Hibberd, Head of Clinical Risk and Compliance Louisa Sorrell, Senior Manager Clinical Compliance

Purpose:	To present an update to the Board of Directors of the internal and external assurance processes.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	• 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. • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 76% of cases. • There were 4 external visits in quarter 2. • Compliance for quarterly review of risk registers is 96.7%	
Recommendations:	The Board of Directors is asked to accept the report.	
Approved by:	D Burbridge	Date: 13 October 2015

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QUARTER 2 COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY DIRECTOR OF CORPORATE AFFAIRS

1. Purpose

1.1 The purpose of this paper is to provide the Board with information regarding internal and external compliance as of 30 September 2015.

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 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.

2.1.3 During quarter 2 the Trust provided feedback on our experience of an inspection to the CQC. During this time it became apparent that the recommendations within the CQC's short report and long report were different. To date we have not received a response back from the CQC as to why there are these differences. However, to ensure we are fully compliant the CQC action plan has been updated to include all the recommendations. Details of the action plan are contained within Appendix A.

2.2 NICE

2.2.1 The Trust either meets all recommendations, or is working towards meeting all recommendations, in 76% of cases (previous quarter was 80%). In 14% of cases, the guidance is under review by a senior clinician. In 8 % of cases the Risk and Compliance Unit are awaiting a response from the Guidance Lead. In 2% 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. At the quarter 1

DCQG the Divisional Directors agreed to follow up all overdue responses with the individuals. This has started to improve performance in some divisions for example division D's overdue responses have reduced from 13 in quarter 1 to 7 in quarter 2.

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	**1**	**0**	**14**
Division B			
3	**0**	**6**	**16**
Division C			
2	**1**	**3**	**25**
Division D			
0	**0**	**7**	**32**

2.3 Other regulatory requirements

2.3.1 The Risk and Compliance Unit also provides support to the Research and Development department in relation the Medicines and Healthcare products Regulatory Agency (MHRA) / Good Clinical Practice (GCP).

2.3.2 Throughout the trust various specialties have systems in place to monitor compliance against specific regulatory requirements for example MHRA compliance within pharmacy, UK Accreditation Services (UKAS) and Human Tissue Authority compliance within laboratories.

2.3.3 During 2015/16 the Senior Manager Clinical Compliance will be liaising with relevant specialties to review their governance arrangements with the aim to:

(a) Understand how they monitor compliance and escalate any gaps in compliance;

(b) identify ways the Risk and Compliance Unit can support the specialties i.e. carry out mock inspections, or audits; and

(c) improve reporting of trust wide compliance to include all regulatory requirements within future compliance reports.

3. Trust Compliance with External Visits/Peer Reviews

3.1 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.

3.2 The table below contains full details of the outcome of the visits that took place in Q2 2015/16.

Inspecting Organisation	Area being inspected	Date of Visit	Outcome of Visit	Assurance Level
UKAS - United Kingdom Accreditation Service	Cellular Pathology	14-16 July 2015	There were 97 non-conformances raised. The Inspection team stated: "In conclusion, and with the exceptions noted and assays being withdrawn by laboratory management, the team confirmed general on-going compliance with the CPA standards, and with respect to ISO15189, it has confidence that the required improvement actions will be given due consideration and action by laboratory management. It is recommended that CPA Accreditation be maintained.	Green-amber
Quality Assurance, East and South East England Specialist Pharmacy Services	GMP of Radiopharmacy Aseptic Unit	2 July 2015	The lead inspector stated that *'the unit is housed in excellent facilities with good systems and staff in place. I have assessed this particular service to be Low Risk.'* There were no Critical deficiencies reported. However, there were: • 2 Major deficiencies that require action within three months; • 6 moderate deficiencies that require action within six months; and • 4 minor deficiencies that need to be addressed within twelve months. There is an action plan in place for all the above deficiencies	Green-amber
UKAS - United Kingdom Accreditation Service	Microbiology	21-23 July 2015	There were 85 non-conformances raised. The Inspection team stated: "The team confirmed general on-going compliance with the bench-level CPA standards, and with respect to the ISO15189, it has confidence in their performance activities, but will require evidence of an effective framework from which it provides the service."	Green-amber
Birmingham Cross City CCG Unannounced Inspection	514,411 and West 2	14 August 2015	"We spoke to several patients and overall the comments received were very positive. We gave feedback to the Deputy Chief Nurse who was aware of the concern relating to incident reporting on one ward and is addressing this."	Green-amber

4. Outcome of Audits

4.1 Specialty Audits

During September 2015 the Risk and Compliance Unit have compiled the specialty audit programmes for the year. Unlike previous years the Risk and Compliance Unit will be sending specialities a list of audits which the specialities should be doing as a minimum to ensure compliance against National Audits and NICE guidance. The Risk and Compliance Unit will also be providing sample audit tools, where available, for the specialities to use.

4.2 National Audits:

4.2.1 The Trust is currently participating in the majority of the national audits as per the 2015/16 National Clinical Audit and Patient Outcomes. There are a small number of audits which the Trust is not participating in due to the following reasons:

(a) Data Collection is not due to be carried out during 2015/16

(b) Trust does not provide the particular services

(c) The cohort of patients seen by the Trust is too low to be included in the audit

(d) It has been agreed by the Medical Director that the Trust will not participate in the audit. For example National Cardiac Arrest Audit.

4.2.2 The Risk and Compliance Unit has recently recruited an Annex U who has been supporting the Senior Manager Corporate Affairs with a review of national audits to identify if specialities are:

(a) completing the national audits to time and target;

(b) carrying out appropriate quality checks on the data submitted to the national audit teams; and

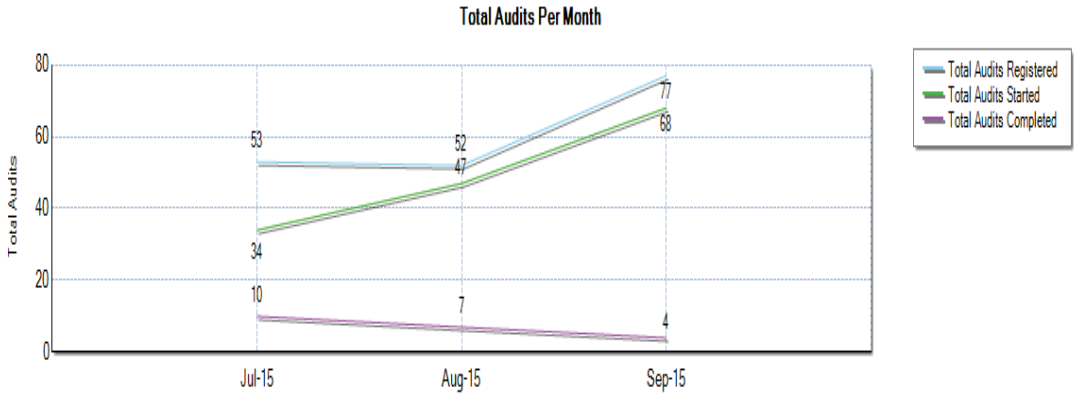
(c) completion of actions identified as a result of recommendations from national audits

4.2.3 The outcome of the review is being presented at the Clinical Quality Monitoring Group in November 2015. A summary of the outcome and full details of compliance will be included in the quarter 3 compliance report.

4.3 Local Audits:

4.3.1 The table below provides an overview of the number of local audits registered on the Trusts Clinical Audit Registration & Management System (CARMS) within quarter 2.

Figure 2: Q2 2015/16 total audits registered



4.3.2 Of the 21 local audits completed within quarter 2 the outcome was:

(a) 7 positive assurance obtained

(b) 8 neutral assurance

(c) 6 weaknesses identified. All of these have an action plans in place .

5. Risk Register Audit

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

Target	Q1	Q2	Q3	Q4
95%	100%	96.7%*		

**Due to timings of some meetings for the quarter 2 risk register review there are 6 risk registers out of 85 where the review meetings are taking place following the date this report has been submitted. The compliance figure is based on these registers being reviewed. If this does not happen an update will be included in the quarter 3 report.*

5.1.2 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.

5.1.3 The audit will be repeated for Quarter 3, 2015-16 to ensure continued monitoring of compliance with the risk register process.

5.1.4 During Q1 2015/16 a review of Risk Register Process was carried out and the following actions have been taken/are being undertaken:

(a) Additional training has been provided to the Risk and Audit Officers (RAO) on risk management and on Health Assure (the software where the risk registers are recorded). Further Risk Management Training is being held on 13 October 2015.

(b) During Q3 the ward risk registers will be reviewed in full to ensure that all relevant risks that need to be escalated to the specialty/departmental risk registers are done so. The interim Clinical Risk Manager will also be ensuring that the ward risk registers contain any risks that are pertinent to the wards cohort of patients to ensure all mitigating actions have been

identified.

(c) During 3 the risk register procedure will be updated to provide greater clarity how risks are escalated on to the relevant risk registers and this will be communicated to staff.

(d) From Q3 an overview of risk register compliance and the number of risks in the Trust will be included in the quarterly Board Assurance Framework report.

6. Recommendation

The Board of Directors is asked to accept this report.

David Burbridge **October 2015**
Director of Corporate Affairs

Appendix A: University Hospitals Birmingham NHS Foundation Trust Draft Action Plan in Response to CQC Recommendations

No.	Domain	CQC Recommendation	Director Lead	Operational Lead	Current Status	Deadline to implement action	Assurance level (RAG rating)
Action the hospital MUST take to improve							
1	Emergency Medicine	**Wording in long report:** 'Improve infection control and cleaning (specific areas). By failing to ensure a clean environment and that staff comply with policies and procedures, the provider is not ensuring that (a) service users, (b) persons employed for the purpose of carrying on the regulated activity and (c) others who may be at risk of exposure to a healthcare-associated infection arising from the carrying on of the registered activity are protected against the risks of acquiring such an infection.' **Wording in Short Report:** 'Improve infection control and hygiene, particularly in Urgent and Emergency Care services.'	Philip Norman, Executive Chief Nurse	Simon Jarvis, Associate Director (Facilities) Liz Miller, ED Matron Debby Edwards, Lead IPC Nurse	• A technical and environmental audit is completed on a monthly basis and in January 2015 the area had a quality score of 97.03%. Any remedial actions that are required are put in place and monitored. This process and monitoring will continue. • In response to the compliance rate for hand hygiene audits the following actions are now in place: o Ensure all staff are up to date with infection prevention and control mandatory training. At the end of Q2 compliance was 93.5% o Complete weekly hand hygiene audits to monitor until compliance is 75% and above. o Promote supportive challenge in all areas o Escalate staff who do not meet the required standard for further support. • Infection Prevention and Control Lead Nurse works closely with the department Matron and Associate Director of Nursing to address any issues. Established link nurses are in place. Team leaders regularly check cleaning record sheets to ensure these are completed correctly; re-emphasising with staff the importance of completing these records accurately. These sheets then form part of the handover between cleaning staff to help prioritise areas depending on actual demand in A&E. Regular checks by Team Leaders on curtains are also underway to ensure they are dated when curtains are changed within the department.	Jun-15	
2		**Wording in long report:** 'Ensure vital sign are recorded as per the patients clinical need. By not ensuring that patient vital signs are checked and recorded in a timely manner, the provider is not ensuring the safe delivery of care and treatment in a way which reflects published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment.' **This recommendation is not in the short report**	Dave Rosser, Executive Medical Director	Dr Javid Kayani, Clinical Service Lead, Liz Miller, ED Matron	All staff aware of the need to record vital signs. Audit of compliance to be undertaken and to determine next steps. Audit of compliance (recording SEWS and Observations) was undertaken in April 2015. The results, learning and required actions have been shared with staff via the ED clinical governance meeting. A rolling programme of audit is now in place.	Jul-15	
3		**Wording in long report:** 'Review mental health assessment room. By failing to provide a suitably appointed mental health assessment room the provider is failing to ensure that service users and others having access to the premises are protected the risks associated with unsafe or unsuitable premises by means of a suitable design and layout.' **This recommendation is not in the short report**	Philip Norman, Executive Chief Nurse	Liz Miller, ED Matron & Karen Johnson, Director of Estates and Facilities	Deputy Chief Nurse has reviewed this room with the Head of RAID (mental health team). Action is in place to minimise any risk (i.e. patients not left unsupervised when in this area). Plans have been drafted by the Matron to relocate this room to a different setting within the Emergency Department, a date for this move is currently awaited.	Jul-15	

4		**Wording in long report:** 'Consultant handovers to junior doctors should be formalised to ensure that when consultants leave the department temporarily, junior staff are supported in relation to their responsibilities. To enable them to deliver care and treatment to service users safely and to an appropriate standard.' **This recommendation is not in the short report**	Dave Rosser, Executive Medical Director	Dr Javid Kayani, Clinical Service Lead	Handover process is in place.	Jun-15	
5	**Surgery**	**Wording in the long report:** 'The Trust MUST ensure that resuscitation equipment is thoroughly checked on each ward and spot checked to ensure compliance.' **This recommendation is not in the short report**	Dave Rosser, Executive Medical Director	Tracey Clatworthy, Resuscitation Services Manager	A Quarterly Audit is undertaken. These are registered audits and will continue and the related reports will be submitted to the Divisional Teams and to the Trusts Resuscitation Committee. From Q3 Quarterly Updates will also be provided to the Clinical Quality Monitoring Group (chaired by Executive Medical Director) via the Patient Safety Group or Directly requested. Where improvements are identified and required, an Incident Form will be submitted for non-compliance & action plans will also be agreed with the clinical teams (via the relevant Associate Director of Nursing) and monitored via the Resuscitation Committee, Patient Safety Group and Clinical Quality Monitoring Group	Jun-15	
Action the hospital SHOULD take to improve							
6	**Emergency Medicine**	**Wording in short report:** 'Continue to monitor effectiveness of Urgent and Emergency Care services to continually inprove patient outcomes.' **This recommendation is not in the long report**	Dave Rosser, Executive Medical Director	Dr Javid Kayani, Clinical Service Lead	An audit programme is in place within Emergency Medicine. Outcomes of audits are reported to the conultant audit lead and shared will colleagues to identify corrective action. The department is partaking in all National Audits	Dec-15	
7		**Wording in long report:** 'Hand washing facilities for visitors should be clearly signposted and staff should ensure it is adhered to.' **This recommendation is not in the short report**	Philip Norman, Executive Chief Nurse	Debby Edwards, Lead IPC Nurse	Signs asking visitors to wash their hands on entry and exit to a ward area are already in place on the entrance door to wards. Additional hand washing signs are being sourced. Hand wash basins are provided inside the ward entrance as is hand gel. Hand gel is also available in all clinical areas. Compliance with this is to be part of hand hygiene audits.	Aug-15	
8	**Surgery**	Wording in long report: 'Patients' records should be consistently completed with all areas of documentation dated and signed appropriately.' **This recommendation is not in the short report**	Philip Norman, Executive Chief Nurse	Louise Denner, Lead Nurse Standards & Bob Hibberd, Head of Clinical Risk and Compliance	Nursing documentation audits are already in place and action plans for improvement are produced and then re-audited. Continue the documentation audit every six months. The next auidt is due to commence in Q3. For the last audit the trust scored 85% (benchmark to meet is 80% or good performance).	Ongoing	
9		Further cross-directorate networking would ensure learning from incidents and complaints was fully embedded across the entire organisation. **This recommendation is not in the short report**	David Burbridge, Director of Corporate Affairs	Lessons Learnt Task & Finish Group	The Trust already provides an aggregated report on trends and actions from complaints, incidents and claims. However, the Trust has a Task and Finish Group in place to identify ways of improved learning across the trust. An action plan is currently being drafted and the group are pulling together some key learning outcomes from recent complaints, incidents etc ready for distribution to staff, via staff team.	Sep-15	

10		Ensure that significant conversations around DNACPR decisions are recorded either in the medical notes or on the electronic record so that staff can be assured that conversations have taken place. **This recommendation is not in the short report**	Philip Norman, Executive Chief Nurse	Dr John Speakman and Tracy Nightingale, EoLC Leads	TEAL/ DNACPR and significant conversation template now operational. Ongoing electronic audit of end of life/ significant conversations with patients and families in place.	Ongoing	
11		Participate in national audits to enable the service to benchmark patient outcomes against other trusts and identify areas for improvement. **This recommendation is not in the short report**	Philip Norman, Executive Chief Nurse	Dr John Speakman and Tracy Nightingale, EoLC Leads	The Trust has completed its participation in the EoLC National Audit. The Risk and Compliance Team have separetly recorded the data submitted and analysed the results which have been shared with the EoLC team to identify appropraiate actions.	Oct-15	
12	**EoLC**	Implement a range of performance indicators for the end of life care and the SPCT to enable them to measure patient outcomes, identify areas for improvement and share good practice. Specifically, the measures should include: o An audit of patients dying in their preferred location. o Targets for rapid and fast track discharge. **This recommendation is not in the short report**	Philip Norman, Executive Chief Nurse	Dr John Speakman and Tracy Nightingale, EoLC Leads	The Trust does not accept the CQCs suggested KPIs as these are for community care. However we do agree that there should be KPIs in place. Initial performance indicators identified and data collection in progress. Reporting and monitoring will be via the End of Life and Bereavement Steering Group which reports into the Care Quality Group. These include SPCT audit of times from referral to patient review and audit of DNACPR/TEAL records to monitor recording of end of life discussions with patients and also families. At the End of Life and Bereavement Steering Group steering group the EoLC national audit was discussed and following completion of this auidt further KPIs will be identified. Dr Speakman has also met with colleagues from QUORU Board to further discuss indicators.	Ongoing	
13		The provider could improve on ensuring staff report all incidents and near misses **This recommendation is not in the short report**	David Burbridge, Director of Corporate Affairs	Bob Hibberd, Head of Clinical Risk and Compliance, Sioux Bailey, OPD group Manager , Debbie Maughan, OPD Matron	Details of how staff can report incidents is available on the Trust's intranet and all staff are made aware of the importance of incident reporting at Trust corporate induction. 100% of staff in outpatients have attended corporate induction. Within outpatients there were 106 incidents reported between 1 July - 31 October 2014 which are reported by a range of staff groups. The extra information shows that details of incident reporting is available to all staff and that incidents are submitted by a wide variety of staff in outpatients. This will continue to be monitored. The Senior Sisters have cascaded information on reporting incidents in Team meetings. Since CQC We are monitoring/recording start and finish times of Clinics time Consultant arrives and use a clinic log for an issues we then complete a Datix to report long waits, we cannot do this for every patient as Datix currently requires we are putting Consultant clinic. We use the OPTIMS System to record delays and send reports to the relevant Speciality GM.	Ongoing	

14		The provider could improve on identifying and reviewing risks and monitoring these on the risk register.	David Burbridge, Director of Corporate Affairs	Bob Hibberd, Head of Clinical Risk and Compliance, Sioux Bailey, OPD group Manager , Debbie Maughan, OPD Matron	The risk register process has been reviewed and the procedure is being updated to make it clearer how risks are escalated from ward risk registers to specialty risk registers. Once updated staff will be informed. Since CQC we have as requested, added risk of 'overcrowding' in sub waits, the control is use of OPTIMS for patient flow and keeping patients informed etc. Improved communication with Specialities GSM and Matron meet with Speciality GM'S to discuss Clinic utilisation and delays, we are further developing OPTIMS to identify test required prior to Consultation to improve patient flow	Aug-15	
15	**OPD only**	The provider could improve on ensuring all emergency resuscitation trolleys are adequately checked **This recommendation is not in the short report**	Dave Rosser, Medical Director	Tracey Clatworthy, Resuscitation Services Manager	A Quarterly Audit is undertaken. These are registered audits and will continue and the related reports will be submitted to the Divisional Teams and to the Trusts Resuscitation Committee. From Q3 Quarterly Updates will also be provided to the Clinical Quality Monitoring Group (chaired by Executive Medical Director) via the Patient Safety Group or Directly requested. Where improvements are identified and required, an Incident Form will be submitted for non-compliance & action plans will also be agreed with the clinical teams (via the relevant Associate Director of Nursing) and monitored via the Resuscitation Committee, Patient Safety Group and Clinical Quality Monitoring Group	Jun 15 and Ongoing	
16		**Wording in long report:** 'The provider was not monitoring the performances and/or did not have sufficient action plans in place for :- waiting times for an oncology diagnosis, 62 days from urgent GP referral to treatment time, waiting times in clinics, overbooking, seeing patients with complex conditions, delayed start to the clinic and seeing emergency patients.' **Wording in short report:** 'Investigate and resolve the long waiting times in outpatient services.'	Cherry West, Executive Chief Operating Officer	Divisional Directors of Operations	The Trust has in place weekly performance assurance meetings to monitor wait times and for RTT and cancer pathways. There are also patient level tracking meetings occurring at specialty level. Both the tracking meetings and the Waiting List Assurance meetings allow operational teams to review all patients on cancer and RTT pathways who do not have an appointment or treatment date within their target date. Every patient past their breach date are also reviewed and monitored. Cancer performance and RTT performance are monitored through the Cancer Steering Group; the Chief Operating Officer's Group; the Chief Executive Advisory Committee; and Trust Board. The Trust will take further action to identify particular milestones and trajectories within the cancer pathway. These will be agreed with the clinical team (via the Divisional Director of Operations). The Trust will put in place operational metrics to monitor clinic 'sitting time' (appointment time vs actual time seen); and clinic late starts. The Trust has in place an Unscheduled Care Group. Through this forum emergency pathways have been developed to reduce wait times in ED. Clinic capacity has been created to achieve this E.g. hand trauma, and rapid access chest pain clinic.	Ongoing	
17		**Wording in short report:** 'Ensure sufficient consultation time is available for patients with complex conditions.' **This recommendation is not in the long report**	Cherry West, Executive Chief Operating Officer	Division C Directors of Operations	The average clinic slot time across the Trust is 20 minutes. The Trust does have some clinic slots of 10 minutes. Clinic slot templates are defined by clinicians and specialty management teams based on the clinical pathway.	N/a	

18		**Wording in short report:** 'Review progress on its 31 day cancer target, especially where radiotherapy is part of the pathway.' **This recommendation is not in the long report**	N/a	N/a	Cancer action plan in place to meet the target. The Trust has advised the CQC that the wording of this recommendation is factually incorrect and 'especially where radiotherapy is part of the pathway' should be removed.	Dec-15	
19	**Trustwide**	**Wording in short report:** 'Ensure appointment to the Children's safeguarding lead post is made.' **This recommendation is not in the long report**	Philip Norman, Executive Chief Nurse	Philip Norman, Executive Chief Nurse	The Trust has a Children's Safeguarding Lead in post sicne Q2 2015/16.	Sep-15	