UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 28 April 2016

Title:	**QUARTER 4 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 CQC carried out a focused inspection in relation to cardiac surgery on 21 and 22 December. Two conditions have been imposed on the Trust as a result of the visit • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 71% of cases. • There were 5 external visits in quarter 4. • Compliance for quarterly review of risk registers is 98.7%	
Recommendations:	The Board of Directors is asked to accept the report.	
Approved by:	D Burbridge	Date: 19 April 2016

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 28 OCTOBER 2015

QUARTER 4 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 31 March 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 are 2 actions which have not been fully implemented, details of the action plan are contained within Appendix A.

2.1.3 Focused Inspection

a) The Trust was notified by the CQC 1 week prior to the inspection that they were going to carry out a focused inspection relating to cardiac surgery on the 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 is 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 to the CQC placed the following 2 conditions on the Trusts registration with the CQC:

(i) Trust is required to commission an external review of the service and this was due to be completed by 31 March 2016; and

(ii) the Trust is required to submit weekly outcome data to the CQC every Wednesday.

c) The Trust has continued to meet the CQC's conditions and the external review of cardiac surgery services was undertaken on the 29th February and 1st March 2016. The external reviewers report was due to be sent to the Trust by 31 March 2016 to meet the CQCs deadline. Unfortunately, despite the Trust fully cooperating with the external reviewers, due to their clinical commitments, they requested a 2 week extension to submit their report, which the CQC subsequently agreed to. The Trust is due to provide the CQC with a response to the recommendations from both the CQC's and external reviewers reports by 22 April 2016.

d) Whilst the majority of the actions in response to the recommendations were already being progressed through the CSQIP, any additional actions identified will be added to the project plan and will be monitored on a weekly basis by the project group. Reports on progress against the project plan will continue to be provided to the Cardiac Surgery Steering Group and the Cardiac Surgery Oversight Group.

2.1.4 Development of CQC Compliance Framework

As previously advised, in the previous Board report, a review of the Trusts CQC compliance framework has been undertaken to identify improvements to the existing process. The outcome of this review and the proposed improvement to the reporting of compliance at speciality, divisional and Board level is being presented at the Director of Corporate Affairs (DCA) Governance Group in May. A project plan to implement the proposed changes will also accompany the report. Details of the proposed changes will be included in the Q1 2016/17 Board report.

2.2 NICE

2.2.1 The Trust either meets all recommendations, or is working towards meeting all recommendations, in 71% of cases. In 19% 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. The Divisional follow-up follow up all overdue responses with the individuals.

Non-Compliant	Partially Compliant	Overdue Response	Under Review / Working towards compliance
Division A			
0	**1**	**1**	**13**
Division B			
1 Not Compliant 3-Awaiting decision from the Divisional Director followed by CQMG-Email sent.	**0**	**12**	**21**
Division C			
2	**1**	**4**	**35**
Division D			
0	**0**	**6**	**46**

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

2.2.3 The Trust has recently started to use the NICE monitoring module in 'Health Assure' web-based tool to improve 'live' reporting of compliance. Training has been rolled out to staff that will be using the tool and all NICE guidance is currently being updated on the system. Work it currently ongoing with informatics to extract this data into the current risk dashboard.

2.3 Other regulatory requirements

2.3.1 In conjunction with the project manager in R&D and service improvement the Clinical Risk and Compliance team are supporting the programme to ensure all of the Trust's physiology services are IQIPs accredited (Improving Quality In Physiological Services). A number of the standards are similar to those that are required to be compliant with CQC regulations and feedback from service leads who's departments are already IQIPS accredited is that output and the quality of the service has improved as a result.

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 Except for the CQC visits see section, above, the table below contains full details of the outcome of the visits that took place in Q4 2015/16. It also included details of the Endocrinology peer review that took place in quarter 3 as the outcome of this visits was unknown at the time of reporting.

Inspecting Organisation	Area being inspected	Date of Visit	Outcome of Visit	Assurance Level
Endocrinology Peer Review	Endocrinology	23 Nov 2015	A draft report has been issued where all standards were either 'met' or 'exceeded'.	Positive
Clinical Commissioning Group	Risk and Compliance	21st January 2016	CCG reviewed all reported incidents of moderate and severe harm for the month of November 2015. Of the 9 reviewed all actions had been undertaken appropriately within the required timescales.	Positive
Health and Safety Executive	Trust wide looking at Safer Sharps	26th Jan 2016	The Inspectors were very positive about the performance of the Trust and specifically commented about the knowledge and commitment of staff at all levels regarding sharps and safe practice. The Inspectors were also impressed by the policies, procedures and general management of sharps throughout the Trust. The inspectors have only found one issue that they considered required formal action - this being that we use hypodermic needles rather than a safer alternative and whilst they recognised the progress made so far to source and introduce a safer alternative, they believed that we should have been able to do this more quickly and a deadline of 31 May 2016 to meet the recommendation has been given.	Partial
Joint Advisory Group	Endoscopy	5th February 2016	The endoscopy unit has met all of the requirements to be awarded JAG Accreditation for 2016.	Positive
Environmental Agency	Pharmacy	1st March 2016	Inspection post incident - loss of a radio isotope vial. Awaiting report.	TBC in Q1 16/17
Home Office	Pharmacy	16th March 2016	In relation to our controlled drugs licence, this inspection covered all the operating procedures including controlled drug destructions, security around the storage units used to store the controlled drugs and the security measures in place around the pharmacy. The inspector was satisfied that the Trust met the requirements laid down by the Home Office and she will be issuing the licence within the next few weeks.	Positive

4. Outcome of Audits

4.1 National Audits:

4.1.1 The Trust is currently participating in 94% (30/32) of the national audits as per the 2015/16 National Clinical Audit and Patient Outcomes Programme. There are a small number of audits which the Trust is not participating in due to the following reasons, which have been agreed by the Medical Director.

4.1.2 The Risk and Compliance Unit have completed a review of the national audits and details of the outcome of the review were presented at the Clinical Quality Monitoring Group (CQMG) in November 2015. The Group agreed the following programme of work should be completed by in order improve the national audit process:

(a) Review staff resource and workload across all divisions for national audit. Based on current model, exception to Div D, some specialties have an audit lead that is or is not fully utilised for audit work and other specialties do not have any resource. The review will aim to look to see if a pool of audit resources would be better and cost effective. This piece of work is due to completed at the end of April 2016.

(b) Implementation of a robust data validation processes

(c) Improved monitoring from risk and compliance including monitoring of actions from national audit reports. This has been implemented and from 2016/17 reports on outcomes form national audits will be reported at speciality meetings.

(d) Cancer Group Audits – there are issues with data submission for all cancer group audits, with the exception of the National Lung Cancer Audit. The main issue is uncertainty over where the responsibility for completing these audits lies (ie Division or Cancer Services). This is complicated by the presence of other datasets that overlap with the audit datasets and the current process by which pathology produce their reports (free text which requires interpretation to input to Somerset). This is being addressed by increased Risk & Compliance involvement with the Cancer Informatics Group with a view to establishing a process for which department submits which data, looking into the mechanism by which pathology produce their reports, and identifying any additional resource that may be required.

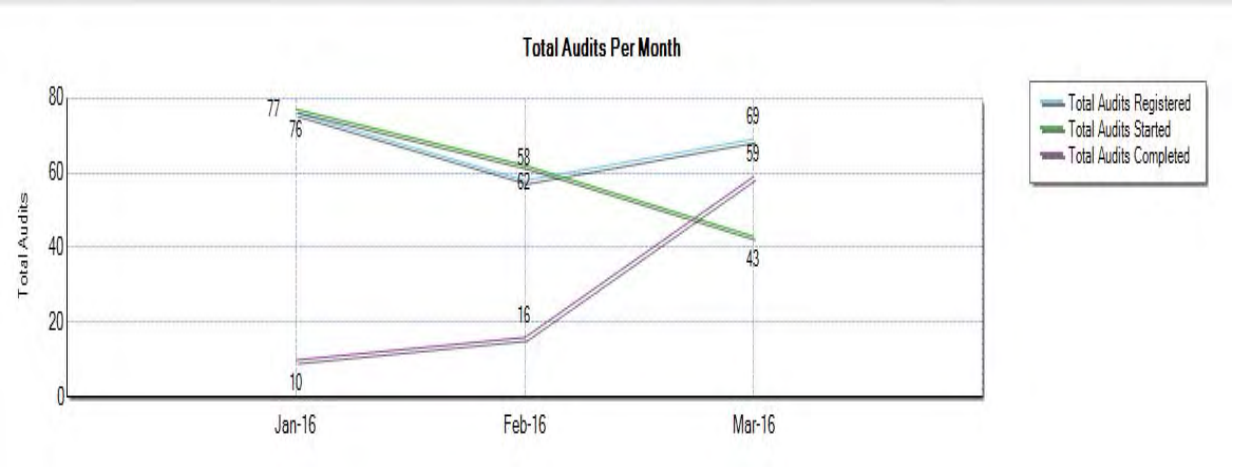
An update on all of the above actions is being presented to the CQMG in May 2016 and will be included in the Q1 2016/17 Board report.

4.2 Local Audits:

4.2.1 The table below provides an overview of the number of local audits

registered on the Trusts Clinical Audit Registration & Management System (CARMS) within quarter 4.

Figure 2: Q4 2015/16 total audits registered



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%	93%	98.7%

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 1, 2016-17 to ensure continued monitoring of compliance with the risk register process.

6. Recommendation

The Board of Directors is asked to accept this report.

David Burbridge **April 2016**
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 Q4 compliance was 71.7% 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.	Ongoing	
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 Departmentand ensure the room complies with the required standard, a date for this move is currently awaited.	Jul-15	

No.	Domain	CQC Recommendation	Director Lead	Operational Lead	Current Status	Deadline to implement action	Assurance level (RAG rating)
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	**Surgery**	**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		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.	Sep-15	

No.	Domain	CQC Recommendation	Director Lead	Operational Lead	Current Status	Deadline to implement action	Assurance level (RAG rating)
10	EoLC	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		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. The outcome of the recent EOLC national audit is currently being reviewed to identify appropriate actions in response to the recommendations.	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	

No.	Domain	CQC Recommendation	Director Lead	Operational Lead	Current Status	Deadline to implement action	Assurance level (RAG rating)
14	OPD only	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		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	

No.	Domain	CQC Recommendation	Director Lead	Operational Lead	Current Status	Deadline to implement action	Assurance level (RAG rating)
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	