UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 25 JANUARY 2018

Title:	**QUARTER 3 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 31 December 2017.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	• There were 3 queries raised by the CQC in Q3 • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 85% of cases (84% in Q1) • There were 3 external visits in Q3 • 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: January 2018

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 25 JANUARY 2018

QUARTER 3 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 31 December 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.

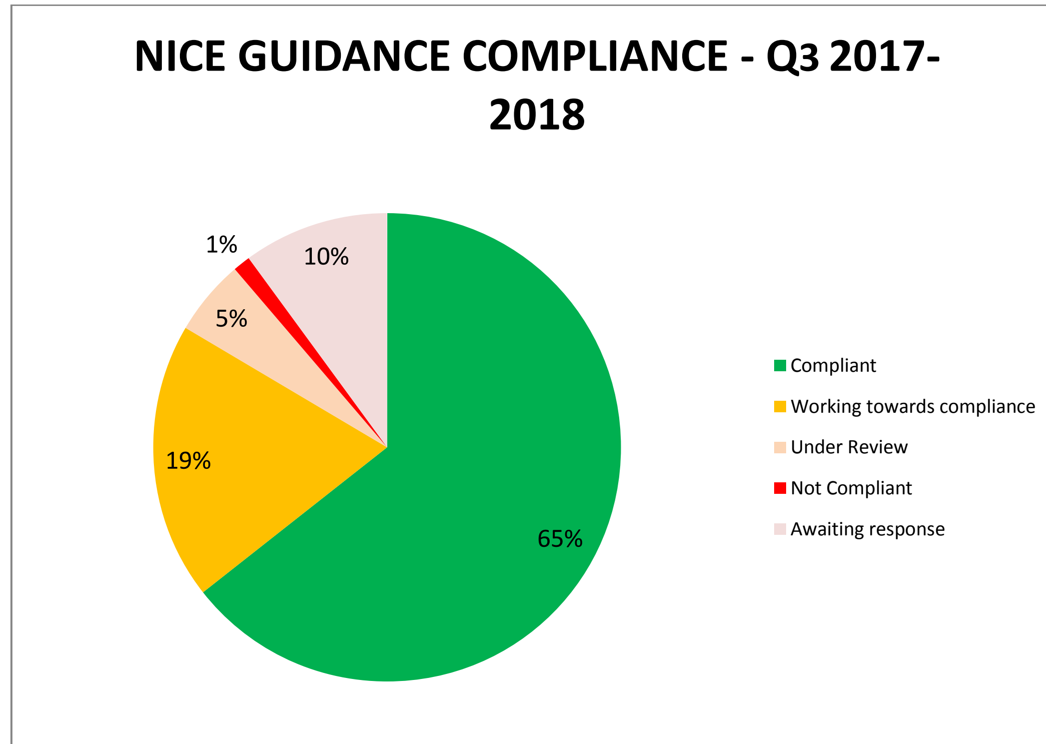
2.1.2 CQC Correspondence

There were 3 complaints/queries raised by the CQC during Q3. CQC have advised that they are satisfied with the responses and actions taken by UHB and have closed the queries. Details of these and any outstanding actions for the Trust are detailed 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 85% of cases (84% in the previous quarter).

Figure 1: Trust compliance with NICE Guidance



4. Trust Compliance with External Visits/Peer Reviews

4.1. There were **3** external visits during Q3. There were **6** visits from previous quarters where the outcomes were unknown at the time of reporting. There were **5** visits where updates on outstanding actions have been received. 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) – **4** 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) – **7** 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 **3** visits and details of these visits will be included in the quarter 4 2017/18 report.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
UKAS (United Kingdom Accreditation Service)	Molecular Pathology	A	13th – 14th June 2017	There were 23 non-conformances raised, and 1 recommendation. Two non-conformances related to patient/user experience, nine non-conformances related to Quality/Governance issues, four non-conformances related to clinical competencies, and seven related to document management and control.	Positive	UKAS has confirmed successful maintenance of accreditation.
Alliance Medical – UK	QEB PET/CT	A	21st June 2017	An external ISO27001 IG audit of the PET Centre was carried out on the 21st June. They were being audited in their role as material subcontractor to Alliance Medical for provision of PET-CT scanning services to NHSE under a 10 year contract.	Positive	Report received in October 2017. Formal feedback was positive with no actions issued to PET/CT centre.
United Kingdom Accreditation Services (UKAS)	Microbiology	A	24th – 25th July 2017	This visit was an accreditation surveillance visit and extension to scope. There were 26 non-conformances found during this visit. The non-conformances related to mostly quality assurance measures, with some also being raised in relation to staff competencies, equipment management and document control. 3 recommendations were made relating to equipment and documentation.	Positive	UKAS has confirmed successful maintenance of accreditation and extension to scope.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
Human Tissue Authority (HTA)	Cellular Pathology / Mortuary Services	A	26th September 2017	Following receipt of the final report at the end of November 2017, seven minor shortfalls were found consisting of three consent, 1 SOP and 3 training issues.	Neutral	A CAPA has been submitted to the HTA with deadlines and actions set for January and March 2018. The Clinical Compliance team will continue to monitor these actions.
NHS England Quality Surveillance Team (QST) - Peer Review Programme	Liver Transplant	B	7th Dec 2016	3 areas of serious concern* relating to patient care/outcomes: 1. 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 2. The 24/7 on-call service for the recipient transplant co-ordinators is not provided by substantive staff during planned and unplanned absence leave and is reliant on bank staff to fulfil some of the on call rota 3. The overall quoracy at the listing MDT meeting is less than 67%.	Neutral	Outstanding actions being followed up via Divisional Clinical Quality Group meetings. Clinical Compliance team to continue to monitor progress.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
NHS England Quality Surveillance Team (QST) - Peer Review Programme	Renal Services	B	8th Dec 2016	3 areas of serious concern* relating to patient care/outcomes: 1. Insufficient numbers of consultant transplant surgeons to deliver a sustainable transplant programme 2. 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 3. The overall quoracy at the listing MDT meeting is less than 67%	Neutral	Outstanding actions being followed up via Divisional Clinical Quality Group meetings. Clinical Compliance team to continue to monitor progress.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
HTA - Human Tissue Authority	Organ Transplantation (Heart, Liver, Renal)	B	20th – 22nd June 2017	Three minor shortfalls were found by the HTA during their visit: 1. The recording of IV drug use in the donor assessment form for living donors. 2. Lack of a documented procedure for keeping information on donor and organ characterisation for 30 years. 3. The use of a histopathology laboratory which is not current accredited by CPA or UKAS, without risk assessing the potential impact on the quality and safety of the organ as a result of this change to accreditation status of the laboratory. The HTA also advised that ODT reviewed discharge letters for living donors, updating operational policy documents, monitoring storage temperature of perfusion fluids, formalising the maintenance of perfusion machines, timely reporting of incidents and shared learning from incidents.	Neutral	Two of the three actions have now been completed and closed by the HTA. UKAS are due to inspect Cellular Pathology in March 2018 which will address the final action. Update to be included in Q4 2017/18 report.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
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. The Quality Lead for Haematology has completed a large piece of work relating to reaccreditation of the service, finalising corrections, updating the local quality manual, and has now fully submitted the data to upload.	Neutral	Submitted documentation to be reviewed by JACIE with a visit to the service likely to be February/March 2018. Update to be included in Q4 2017/18 report.
JAG (Joint Advisory Group on GI Endoscopy)	Endoscopy	B	1st August 2017	Initial feedback following the visit was positive; three minor standards required being actioned within two weeks of the visit.	Positive	Full accreditation was granted to the service on 21st November 2017
NHSE QST (Quality Surveillance Team)	Pulmonary Hypertension	B	16th November 2017	Extremely positive feedback. They found the services to be very patient-centred and praised the CNS' excellent face-to-face communication. No Immediate or Serious Concerns were raised.	TBC	Final report has not yet been received. Update to be included in Q4 2017/18 report.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
GIRFT (Getting it Right First Time)	Cardiothoracic	B	25th September 2017	Staff reported a positive visit from the GIRFT team, with a feedback report being received on 31/10/17. There were 8 recommendations made in total,: 1. Clinical outcome monitoring. 2. Volume of activity (this could be improved) 3. Ring-fenced beds 4. DOSA 5. Cancellation rate and stay 6. Aortovascular rota 7. Coding 8. Data	Neutral	Actions to be completed within three to six months (January through March 2018). Update to be included in Q4 2017/18 report.
GIRFT (Getting it Right First Time)	Maxillofacial	D	5th October 2017	The initial feedback from the visit was positive – awaiting final report.	TBC	Update to be included in Q4 2017/18 report.
National Institute for Cardiovascular Research (NICOR)	Cardiovascular	B	5th December 2017	Audit of consent forms from 20 patient files. Initial comments were positive – awaiting final report.	TBC	Update to be included in Q4 2017/18 report.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
NHS QST	Urology	D	25th July 2017	Initial feedback given to the MDT was positive. The final report was received on 11/12/17 - no immediate risks were identified. There were two areas of serious concern* raised: 1. Insufficient CNS establishment – though patient safety is not at risk, establishment should be increased. 2. No robotic surgery offered at UHB.	Neutral	This is being overseen by the Head of Cancer services. NHSE QST have not requested an action plan or given a deadline to implement the 'serious concerns'.

* a "serious concern" is defined as 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.

5. Outcome of Audits

5.1. National Audits:

5.1.1. The Trust is currently either participating in or scheduled to participate in 33/35 National Audits listed on the HQIP Quality Accounts during 2017/18.

5.1.2. 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.

5.1.3. 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 12 months.

Quarter	Month	Total Audits Registered	Total Audits Started	Total Audits Completed
3 - 2017/18	October	99	89	19
	November	81	70	11
	December	72	48	10
2 - 2017/18	July	56	42	13
	August	43	41	8
	September	67	67	22
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

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%	97%	98%	

7. Recommendation

The Board of Directors is asked to accept this report.

David Burbridge **January 2018**
Director of Corporate Affairs

Appendix A: Queries raised by the CQC

The table below provides details of any queries raised by the CQC during Q3 including any complete, ongoing or outstanding actions.

Date	Division	Request or contact description	Findings of investigation & CQC response
05/10/2017	A & B	The CQC emailed regarding a number of complaints received from the relatives of a patient who died following treatment on Critical Care and Ward 305.	A thorough investigation was carried out following this complaint prior to this request from the CQC; a formal response was written and posted to the family on 15th September from the Interim Chief Nurse. The investigation and response was very comprehensive; this was sent to the CQC in response to their request which they were satisfied answered all of their queries.
01/11/2017	C	The CQC received notification of a Safeguarding concern on Ward 513. This included concern over the lack of 1:1 care, 'mouldy' food served to the patient, and the patient being left in a soiled incontinence pad overnight.	An investigation into each issue raised was carried out by the Risk and Compliance team which found that each concern raised had been dealt with professionally by the ward/relevant department. The CQC were satisfied with the outcome of the report and confirmed that the Local Authority are taking no further action in relation to safeguarding.
20/11/2017	A	The CQC contacted the Trust regarding a review of all NHS acute and community Trusts in relation to the timescales for reporting radiology examinations as they are aware there has been significant backlogs of radiology reporting in some Trusts. The following information was requested: 1. Local key performance indicators (KPIs) for report turnaround times set out by modality. 2. The proportion of patients that have breached trust reporting turnaround time KPIs expressed as a percentage, broken down by modality and urgency, over the last 3 months up to and including 31 October 2017. 3. The number of unreported examinations as of the	All information requested by the CQC was provided and returned by Paul Brettle by the requested deadline. Awaiting outcome report/response from the CQC.

Date	Division	Request or contact description	Findings of investigation & CQC response
		date of this letter, broken down by those that are within and outside of local KPIs. 4. Details for local monitoring of report turnaround times. 5. What are your internal triggers/KPIs to alert you that any reporting backlog requires action and how is this achieved? 6. What examinations are not routinely reported by radiology? 7. Do you outsource any reporting and if what percentage of the total examinations are outsourced (please specify if this is in-hours or out of hours)? 8. The number of WTE radiologist posts and vacancies. Are any of these vacancies covered by locums currently? 9. The number of reporting radiographers broken down by modality, including whether you offer hot/cold radiographer reporting?	