UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 26 OCTOBER 2017

Title:	**QUARTER 2 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 September 2017.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	• There were 5 queries raised by the CQC in Q2 • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 85% of cases (84% in Q1) • There were 4 external visits in Q2 • Compliance for quarterly review of risk registers is 97%	
Recommendations:	The Board of Directors is asked to accept the report.	
Approved by:	D Burbridge	Date: October 2017

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BOARD OF DIRECTORS

THURSDAY 26 OCTOBER 2017

QUARTER 2 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 September 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 Section 2.1.3 of this report details outcomes from any inspections during quarter 2 and an update on any outcomes from existing inspections.

2.1.3 CQC Inspections

(a) Assure Dialysis Unit, Smethwick

On 5 June 2017 the CQC carried out an announced inspection on the Assure Dialysis unit. A follow-up unannounced inspection was then carried out on 15 June 2017 along with an additional data request. The final report was received on 4 September 2017; the CQC issued three requirement notices, however confirmed that regulation had not been breached. The requirement notices were:

I. staff were using a technique 'dry needling' in such a way air could be transported into patients' blood stream potentially causing an air embolus. There is currently no national consensus on dry needling versus wet needling. Although dry needling is an approved safe method, the unit has since implemented the 'wet needling' technique and is now the only method of needling used, as favoured by the CQC.
II. identification checks were not being completed when collecting and administering medicine, and connecting patients to dialysis machines.
III. although the provider had a well-developed risk assessment document (risk register) in place; they had not recognised the risk of non-compliance with action plans from other parties; for example the facilities team.

An action plan was submitted to the CQC on 5 October to address and rectify these requirements which has been accepted with no queries. This

action plan will be monitored at the monthly Assure Dialysis business meetings to ensure the actions are implemented and maintained.

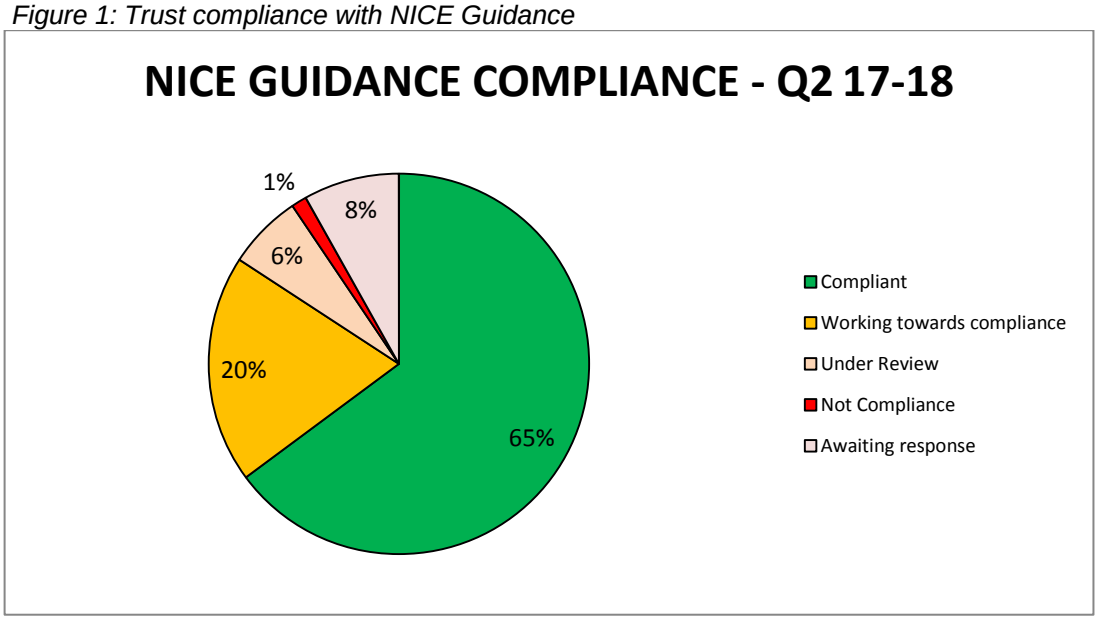
2.1.4 CQC Correspondence

There were 5 complaints/queries raised by the CQC during Q2. CQC have advised that they are satisfied with the responses and actions taken by UHB. Details of these and any outstanding actions 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 4 external visits during Q2. The table below also include 2 visits from previous quarters where the outcomes were unknown at the time of reporting and 2 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) – **3** 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) – **2** 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 3 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)	Biochemistry	A	15th – 16th March 2017	There were 7 non-conformances noted by the assessors. These related to document control and equipment management. There was one recommendation also relating to the equipment management.	Positive	All non-conformances have been actioned and addressed; UKAS have confirmed successful maintenance of accreditation.
UKAS (United Kingdom Accreditation Service)	Haematology	A	27th March 2017	9 areas of non-conformity were mainly indicating a need for managerial review of the quality management system.	Positive	All non-conformances have been actioned and addressed; UKAS have confirmed successful maintenance of accreditation.
UKAS (United Kingdom Accreditation Service)	Molecular Pathology	A	13th – 14th June 2017	There were 23 non-conformances raised, and 1 recommendation. Two non-compliances related to patient/user experience, nine non-compliances related to Quality/Governance issues, four non-compliances related to clinical competencies, and seven related to document management and control.	Neutral	This was an initial application visit therefore the service had 12 weeks to demonstrate that they have corrected the issues raised. Evidence was submitted to UKAS by the deadline. Awaiting action plan.
United Kingdom Accreditation Services (UKAS)	Microbiology	A	24th July 2017	This visit was for an extension of scope. 8 non-conformances were identified which fell into four	TBC	The lab has until 17/10/17 to address these issues and submit evidence to UKAS.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
				categories; temperature mapping, clinical competences, document control, and quality assurance measures. There was also 1 recommendation made also relating to document control.		TBC in Q3 2017/18 report.
United Kingdom Accreditation Services (UKAS)	Microbiology	A	25th July 2017	This visit was an accreditation surveillance visit. 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.	TBC	All actions have been completed by the lab and submitted to UKAS. Awaiting feedback following submission. TBC in Q3 2017/18 report.
Human Tissue Authority (HTA)	Cellular Pathology / Mortuary Services	A	26th September 2017	Initial feedback from this visit was positive, with the inspectors observing a strong team who responded well to a difficult situation. Facilities were noted as very good. Training will be identified as an improvement, to be confirmed at what level when report received. Some	TBC	Awaiting report – TBC in Q3 2017/18 report

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
				strengthening of quality assurance measures will be recommended.		
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 to be added 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.	Neutral	A CAPA action plan was required to be returned to the HTA within 14 days to address each shortfall. This has been submitted and agreed by the HTA; the division has 3-6 months to complete the actions. The Risk And Compliance Team will monitor the division's progress with these actions to ensure they are complete within this time.
Birmingham CCG	Diabetes Care	C	18th July 2017	The CCG carried out an unannounced inspection of Diabetes Care to meet staff involved in the speciality to discuss the work they have been undertaking to improve the care of patients with diabetes. This was	Positive	No CCG recommendations or actions identified from the visit.

Inspecting Organisation	Area being inspected	Division	Date of Visit	Outcome of Visit	Assurance Level	Assurance / outstanding actions
				further to concerns following three serious incidents that were raised in November 2015. The concerns were not specific to one clinical area and all related to different aspects of diabetes care. The CCG were encouraged by the enthusiasm of the teams involved and the significant hard work that has been undertaken to date.		

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
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
3 – 2016/17	October	86	95	10
	November	83	73	28
	December	55	45	24

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%		

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 Q2 including any complete, ongoing or outstanding actions.

Date of request or contact	Division	Request or contact description	Findings of investigation & CQC response
05/07/2017	Corporate	The CQC received a concern about new paperwork that is being used on the medical wards. The anonymous caller claims that the paperwork contains sensitive and confidential information and that it is stored in the bed end folder which can easily be accessed by patients/relatives.	The Lead Nurse Standards and Senior Manager (Information Governance) undertook a Privacy Impact Assessment which did show some areas that needed to be amended. Accordingly, a number of actions were recommended and changes to the documentation were implemented. The CQC were satisfied with our response. The new documentation is currently being rolled out across the rest of the in-patient wards using the final format and storage arrangements.
28/07/2017	D	The CQC contacted us regarding two areas of concern: 1. A patient has contacted them on several occasions to complain about the services she received in 2011 and 2012. Concerns relate to ENT and theatres. The CQC requested details of the patient's complaints and the trust's responses. 2. The CQC requested details regarding the two never events that occurred in May 2017, including RCAs.	1. Complaints from this patient have been received since 2015 although the surgery being referred to occurred in 2012. Nonetheless the complaints have been investigated and responded to accordingly. The details were forwarded to the CQC who were satisfied with our actions and response to this patient's complaints. 2. Details of both never events (occurring 21st March 2017 and 18th May 2017) have been forwarded to the CQC including the final investigation reports. The CQC are satisfied with our response.

Date of request or contact	Division	Request or contact description	Findings of investigation & CQC response
09/08/2017	B	The CQC received a concern raised by a relative about the care of their mother. They alleged that their mother was left in blood soaked clothes for two days and also waited four days for an urgent blood transfusion. They also raised concerns regarding delays in gaining access to the ward and issues in relation to their own care. CQC requested confirmation that UHB have received a complaint from this person and the action we are taking/have taken in relation to the concerns he raises.	Our complaints team contacted the relative to discuss his concerns who confirmed that the concerns he mentioned relating to his mother's care are now resolved. The Matron also visited the ward (ward 305) and no immediate issues or concerns were identified. The CQC responded to ask whether the complaints made in relation to the wait for an urgent blood transfusion and his mother being left in blood soaked clothes for two days were investigated and if so, whether they were substantiated. Following the Matron's visit to the ward, which included a review of the concerns raised, review of documentation and discussion with nursing staff and following the ward Senor Sister's discussion with the relative, the concerns were not substantiated. The patient said she was 'mortified' that her relative had raised such concerns. The patient is adamant that she has no concerns regarding her care and no experience of being left in wet clothing. The patient advised that she had also been in contact with her relative. The Matron has also attempted to make contact with the relative to reassure them of her investigation into their concerns. The CQC were satisfied with our response.
14/08/2017	D	The CQC received a concern raised by a patient regarding concerns over her treatment at UHB after transferring her treatment plan from another NHS Trust. She alleges that she was 'punished' for moving Trusts. The patient also believes that her consultant was not compassionate when delivering care, which	An investigation into the patient's complaints is underway and a written complaint response will be sent to them once this is concluded. From the information currently available we do not believe the concerns raised are substantiated. Since this time the patient has contacted the Trust on the 6 September 2017 and requested some further information. She queried if her medical records have been sent from the Trust to Gloucester Hospital. The Head of Patient Services has advised that following receipt of a letter from her GP (31 August 2017), the patient's information was sent to Gloucester Hospital from us.

Date of request or contact	Division	Request or contact description	Findings of investigation & CQC response
		reinforces her opinion on being 'punished' for moving Trust.	A written response from the Trust is currently being finalised and is due to be sent on 11 October 2017.
01/09/2017	C, D	The CQC contacted us regarding three areas of concern: 1. A complaint was made regarding the care delivered to a relative at the end of their life. The patient died following a fall on ward 622 in March this year. The family have raised concerns regarding the staffing levels on the ward. 2. A complaint was received that relates to the attitude and care provided by staff within the ED. The relatives claim that staff were rude and on two separate occasions they had been discharged home without adequate pain relief and told to buy it from a shop. 3. Complaint about care on Ward 410, specifically regarding patients not	1. A breakdown of staffing on ward 622 over the time period provided was given to the CQC; over the 14 week period there were nine occasions in which the ward fell below the acceptable minimum staffing numbers. An explanation of the processes involved in maintaining safe staffing on the ward was provided to the CQC and they were informed that 10 newly qualified registered nurses are due to start in this area during September and October 2017. 2. We have not been able to investigate the specific elements of this complaint because we do not have the patient details. However the Matron for the Emergency Department has given assurance that staff in the Emergency Department will ensure that patients who are discharged from the ED are always sent home with appropriate analgesia, as per the Trust policy. The Matron has stated that the only time pain relief would not be specifically prescribed, when needed, would be if simple analgesia is required, and would be much cheaper for the patient to buy over the counter, rather than pay for a full prescription charge e.g. a packet of paracetamol or ibuprofen. 3. This complaint was investigated and found no incidents or complaints relating to lack of food for patients. A nutritional audit was also carried out on ward 410 in August 2017 which also found that no meals had been missed during the audit. The CQC are happy with the current status of the responses and await further details on the following in December 2017: The CQC were satisfied with our response and will seek clarification on the

Date of request or contact	Division	Request or contact description	Findings of investigation & CQC response
		receiving food, and the length of time it takes for the call buzzer to be answered. The patient's family contacted the CQC to raise concerns over their family member not receiving food at meal times on two occasions since the middle of August. On both occasions the family claim the nurse in charge told them this is because they have 'ran out of food for all the patients'. The family told the CQC that this resulted in them taking their relative to the hospital canteen to ensure they received a hot meal that day.	following as part of the regular relationship meetings with the Chief Nurse and Head of Clinical Risk and Compliance: 1. staffing figures on ward 622 when the new staff nurses have started 2. how the Trust monitors call buzzer data