UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 24 OCTOBER 2019

Title:	**COMPLIANCE AND ASSURANCE REPORT – Q2**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Sylvie Bidonde, Interim Head of Clinical Governance and Patient Safety, 16111

Purpose:	To present an update to the Board of Directors with information regarding internal and external compliance as of 30th September 2019.
Confidentiality Level & Reason:	None
Strategy Implementation Plan Ref:	#4 Meet regulatory requirements and operational performance standards, in line with agreed trajectories
Key Issues Summary:	• The CQC carried out two unannounced focused inspections. • The CQC placed a condition on UHBs Diagnostic and Screening Procedures registration for the Good Hope license. • There were 27 queries raised by the CQC. • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations in 33% of cases. • There were 11 external visits. • The Trust received 2 Regulation 28 reports.
Recommendations:	The Board of Directors is asked to accept the report.

Signed: David Burbridge	**Date:** 16 OCTOBER 2019

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 24 OCTOBER 2019

COMPLIANCE AND ASSURANCE REPORT – Q2

PRESENTED BY DIRECTOR OF CORPORATE AFFAIRS

1. Purpose

The purpose of this paper is to present an update to the Board of Directors on the internal and external assurance processes as of 30th June 2019.

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 Corporate Affairs Directorate currently has specific oversight of the CQC requirements.

2.1.2 The report from the latest CQC inspection was published on the CQC website, together with the evidence log, on 13 February 2019. The report identifies a number of actions the Trust must take to ensure compliance with the CQC standards. These actions have been shared with the responsible leads and an action plan has been agreed. This was returned to the CQC on 12th April 2019.

2.1.3 There is an agreed process in place to monitor progress with the action plan for all "must do" actions, with the Director of Corporate Affairs' Governance Group responsible for overall monitoring, with specific actions being monitored at the appropriate Trust group.

2.1.4 Actions the CQC designated as "should do" have largely been incorporated into the compliance framework (detailed in 2.4.) for ongoing monitoring as well as being disseminated to the relevant divisions for inclusion in governance assurance meetings.

2.2 CQC Inspections

2.2.1 On 23rd July an unannounced inspection was carried out on ward 29 at Heartlands Hospital prompted by a series of whistle-blower complaints.

2.2.2 The CQC were satisfied that during inspection they have found no evidence to support the concerns raised by the serial whistle blower and commended the ongoing improvement work that is taking place across the wards providing care for Older People.

2.2.3 The final report was published on 27th September; the report does not impact on the Trust's overall rating, however, the CQC have expressed increased confidence in the Trust's improvement work and engagement of staff in improving care for patients. There are no further actions for the Trust to take in relation to this inspection.

2.2.4 On 22nd August an unannounced inspection was carried out on the Diagnostic Imaging department at Good Hope Hospital.

2.2.5 This inspection was undertaken following concerns raised from a Regulation 28 report from the Coroner and, following subsequent information requests, the CQC did not feel assured that changes were being implemented to prevent future deaths and keep patients safe.

2.2.6 The CQC imposed conditions on UHB's registration in respect of Diagnostic and Screening Procedures at Good Hope Hospital under Section 31 of the Health and Social Care Act 2018.

2.2.7 The Trust is required to report the following to the CQC each month until further notice:

i. The actions taken to ensure that there is an effective system implemented across the department;

ii. Action taken to ensure the system is being audited, monitored and continues to be followed;

iii. Inclusion of the results of any monitoring data and audits undertaken.

2.2.8 The division will be compiling a report incorporating all of the necessary assurance information that will go through the Trust's internal assurance processes before being submitted to the CQC each month.

2.3 <u>Outstanding actions that relate to previous CQC inspections or correspondence</u>

2.3.1 Prior to the CQC inspection that took place in October 2018, both QEHB and HGS action plans were re-reviewed and the following 'must do' actions remain outstanding:

a) QEHB: There remains one outstanding action from CQC's inspection in January 2015 regarding the lack of a Mental Health assessment room. The building works for the room have been completed and was handed over from estates in February 2019. Division 3 ordered furniture following advice from the Liaison Psychiatry Service which is now in place. The Mental Health Trust can now start the application process for Accreditation with PLAN and the room will be assessed for suitability as part of this; this will take approximately 6 months.

b) BHH, GHH, SH: From the inspection in September/October 2016, all but one of the actions has been completed. The only outstanding action is that the hospital did not collect data to determine rates of surgical site infection at Solihull

Hospital. This work is being led by the Divisional Director for Division 4 (previously Division 5).

2.4 CQC Queries

2.4.1 There were 27 queries raised by the CQC in Q2. 10 of these queries have been closed by the CQC as they have advised that they are satisfied with the responses and actions taken by the Trust. The remaining responses are awaiting final sign-off or continue to be investigated.

2.4.2 There is ongoing communication with the CQC, including monthly conference calls and regular face-to-face engagement meetings to discuss outstanding queries and ongoing initiatives.

2.5 Compliance Framework There is a framework in place to ensure the Trust is compliant with external regulation. The measures that are included in the framework have been put together following a review of various external standards; this includes the CQC Fundamental Standards, existing peer review standards e.g. NHS England Peer Review Programme and accreditation requirements e.g. JAG, Clinical Compliance Team to ensure that specialties in all divisions meet the requirements of the compliance framework. Outcome reports and action plans are updated every quarter by the Clinical Compliance Team and monitored via Specialty meetings, Divisional meetings and Director of Corporate Affairs Governance Group meetings.

2.5.3. The Corporate Compliance Team has also reviewed their compliance framework and the monitoring of policies as part of the ongoing preparation for well-led inspections.

2.6. Regulation 28 – Prevention of Future Death Reports

2.6.1. In Q2 the Trust received two Regulation 28 reports:

a) A patient underwent a pacemaker box change on 15th June 2016 and subsequently became unwell on a number of occasions. He visited Good Hope on 6th Feb 2017, his GP on a number of occasions and Burton Queens hospital in August 2017. No consideration appears to have been given that the pacemaker box change may have been the source of his undiagnosed infections. At inquest there was no evidence of a referral process for patients having undergone pacemaker surgery who subsequently become unwell. The Trust's response to the coroner was sent on 24th July 2019 outlining three actions the specialty are undertaking; the deadline for completion of these actions is November 2019.

b) On 19/11/18, the deceased had an unwitnessed fall at home and was admitted to the Emergency Department at Birmingham Heartlands Hospital where he was diagnosed with a fractured neck of the right humerus. He was to be admitted to Ward 24 where the fracture was to be treated

conservatively using a brace. He developed pneumonia due to aspirating food and was treated with IV antibiotics. His condition rapidly deteriorated as a result of this, and despite appropriate treatment, he sadly passed away. The Trusts response was sent to the coroner on 1st October 2019 outlining two actions which are underway.

3. NICE

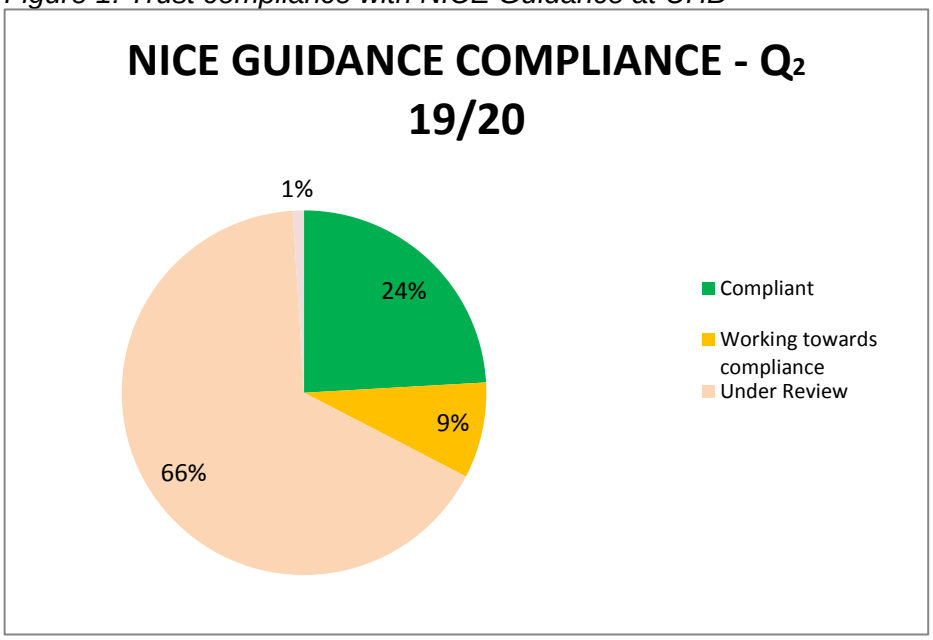
3.1. The graph overleaf shows the current compliance levels for NICE guidance. This was previously reported separately as QEHB and HGS, but has now been reported at UHB level to reflect the new operational structure for specialties and divisions.

3.2. The reporting at overall UHB level has led to a decrease in reported compliance as a specialty must now be compliant across all 4 sites to be considered compliant.

3.3. Compliance with guidance will be monitored on a quarterly basis and it is envisaged that the compliance rate will increase significantly each quarter as the services and processes align and as more NICE guidelines are reviewed.

3.4. The Trust currently either meets all recommendations, or is working towards meeting all recommendations, in 33% of cases. In 66% of cases the guidance is under review by a senior clinician and 1% are awaiting responses.

Figure 1: Trust compliance with NICE Guidance at UHB



4. Trust Compliance with External Visits/Peer Reviews

4.1. Across UHB, there were **11** external visits during Q2 19/20. The table below also included updates from **1** visit from previous quarters where the report had not yet been received or where updates have been received since the time of reporting. These are detailed below:

4.1.1. Positive assurance (Maintained accreditation (where applicable) with only minor areas for improvement required or all identified issues addressed and accreditation (where applicable) achieved) – **7** visits

4.1.2. Neutral assurance (Maintained accreditation (where applicable) with areas for improvement – Action plan required to address significant areas for improvement) – **0** visits

4.1.3. Negative assurance (Maintained accreditation) with significant areas for improvement - – Action plan required to address significant areas for improvement) – **0** visits

4.1.4. Risk to Service continuity/loss of accreditation – Accreditation has been removed – **0** visits

4.2. The Trust is awaiting the outcome of **5** external visits. The outcome of these will be provided / updated in the Q3 19/20 report.

Div	Inspecting Organisation	Area being inspected	Date of Visit	Outcome of Visit	Assurance Level
All	Birmingham Clinical Commissioning Group	Tissue Viability Services	29/04/19	A visit by the CCG to the Tissue Viability Team to QEHB to discuss the rise in grade 2 hospital acquired pressure ulcers. Report now received, the CCG are happy with actions taken by the Trust.	Positive
1	UKAS (United Kingdom Accreditation Services) for ISO15189	Microbiology	23/08/19	Yearly accreditation of maintenance visit. No report yet received, this is expected back from UKAS in Q3.	TBC in Q3 2019/20 report
1	UKAS (United Kingdom Accreditation Services) for ISO17043	NEQAS (National External Quality Assessment Services) for Birmingham	03/07/19 & 04/07/19	Positive visit, full cycle assessment of the service. Nine minor mandatory findings and two recommendations made. All have been addressed and are currently in a queue with a UKAS decision maker to be fully cleared.	Positive
5	SQAS (Screening Quality Assurance Service)	Breast Screening	09/07/19	Positive visit with one immediate recommendation made prior to the receipt of the full report (recommendation made to start succession planning for a replacement for the Breast Services Manager). An action plan is being developed for this and a draft report from SQAS is expected in Q3.	TBC in Q3 2019/20 report
5	BSI (British Standards Institute) for ISO9001	Oncology	11/09/19	Visit to close off the remaining action from previous visit on 03/03/19. Now closed.	Positive

3	Solihull SupportUHome	Delayed Transfer of Care Programme – Solihull Local Government Association	18/06/19 – 21/06/19	A positive visit – several minor recommendations made. An action plan is currently with the programme board for sign off.	Positive
1	Radiotherapy	BSI (British Standards Institution) for ISO9001:2015	10/09/19 – 11/09/19	One minor non-conformance found at previous visit, specialty have an action plan in place and this is expected to be cleared at this visit.	TBC in Q3 2019/20 report
1	Molecular Pathology	UKAS (United Kingdom Accreditation Services) for ISO15189	09/07/19	Three minor non-conformances found and one recommendation made. All closed out by UKAS and maintenance of accreditation has now been granted.	Positive
1	RRPPS – Radiation Protection Services	HSE (Health & Safety Executive)	31/07/19	An unexpected HSE inspection in relation to compliance with the Ionising Radiations Regulations 2017. A notification of contravention of IRR17 was issued with respect to the risk assessment. RRPPS have already developed a new risk assessment; all required information was submitted to the HSE by the deadline.	Positive
5	Radiotherapy	BSI (British Standards Institution) for ISO9001:2015	05/09/19	An assessment by BSI of the Radiotherapy Clinical Computing Service (CCISS) for extension of scope to current accreditation – this was granted on inspection.	Positive

2	Rheumatology	Lupus UK (National Charity)	17/09/19	Lupus UK promote a small number of Lupus units around the country as 'Centres of Excellence' – QEHB currently hold this and is a re-assessment for the award.	TBC in Q3 2019/20 report
2	Cardiology / ACHD	NICOR (National Institute of Cardiovascular Outcomes Research)	12/09/19	Annual audit of patient records – TBC	TBC in Q3 2019/20 report

5. Recommendation

The Board of Directors is asked to accept this report.

David Burbridge
Director of Corporate Affairs
October 2019