The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	24th June 2013
Title:	Care Quality Commission (Compliance Report)
Executive Summary:	The report highlights corporate compliance with the CQC Essential Standards of Quality and Safety (ESQS) over 12/13 year period.
Action Requested:	That the board notes the current compliance and actions identified to address gaps.
Report of:	Compliance Manager
Author: **Contact Details:**	Sue Hickman Tel 01902 695116 Email suehickman@nhs.net
Resource Implications:	Within existing resources
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	Compliance Committee (6th June 2013)
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: Equality of treatment and access to services High standards of excellence and professionalism Service user preferences Cross community working Best Value Accountability through local influence and scrutiny

Background Details

1 In line with the Health and Social Care Act 2008 (the act) the Trust registered with the CQC in April 2010 with no conditions on its registration. The Trust is registered to deliver the following regulated activity defined by the act:

- Treatment of disease, disorder or injury
- Surgical Procedures
- Diagnostic and screening procedures
- Nursing Care
- Maternity and Midwifery Services
- Termination of Pregnancy
- Family Planning Services
- Management of supply of blood and blood derived products

Of the 28 regulations within the act 16 relate to the quality and safety of care and is the focus of the CQC registration standards (Essential Standards of Quality and Safety

ESQS). To maintain registration the Trust is required to establish systems to monitor and review compliance with the ESQS.

1. CQC compliance is monitored at corporate level via Health assure.
2. Attachment 1 provides an overview of compliance scores for year period 12/13.
3. Attachment 2 provides a detailed highlight report showing rationale for scores provided as well as any actions required/on-going. This report also gives a comparison between the Trust compliance score and the QRP (Quality and Risk Profile) score given by the CQC (June 2013). Status updates were requested from outcome sponsors/leads May 2013. Following presentation of the compliance report to the Compliance Committee 6th June it was highlighted the timeliness of status updates from corporate leads has been a concern. The Chief Operating Officer agreed to follow up this concern with the relevant leads and updates will be submitted by the end of June 2013.

4. Trust compliance score key:

Red	Non compliant
Amber	Partially compliant with Actions Required
Green	Compliant

5. **Scrutiny of on-going monitoring**

Corporate forums have been identified to ensure scrutiny and challenge of reported compliance with each of the outcomes. These forums are expected to identify corporate and/or local actions required by Divisions / Directorates to deliver improvement based on central intelligence.

The list below indicates some of the data used to make a judgement of compliance for each outcome : (this list is not exhaustive)

- Performance reports (KPI's, Nursing Metrics)
- Compliance with national guidance
- Risks / complaints/ claims
- Compliance with national guidance recommendations
- External inspection reports and recommendations

Compliance Committee receives 4 monthly reports in relation to the outcomes, the next report is due October 2013.

6. **CQC visits within financial year 2012/13**

During the financial year the CQC visited the Trust on 2 occasions as detailed below:

CQC Inspection date	CQC outcomes assessed	Compliance findings
25/07/2012	Responsive review Outcome 4 and 16	**Moderate concerns** with regards to safe surgical practice in theatres.
24/01/2013	CQC unannounced inspection to review outstanding actions from previous visit July 2012	**No concerns** – significant improvements made

		with regards to theatres and the implementation of the WHO checklist

All concerns were addressed via action plans which have been implemented and completed to the satisfaction of the CQC. Improvements have been validated by CQC and confirmed full compliance is published on the CQC website.

The CQC have no current concerns regarding Trust compliance with any of the outcomes

The Trust is developing processes to improve assurance on CQC compliance monitoring via Allocate software. Triangulation intelligence from KPI, audits, patient and staff feedback/survey, quality review will inform the system as well as the current QRP.

Conclusion

The Trust has a level of assurance around the capture of information for corporate compliance and the standards. There remains further development work to strengthen consistency and the indicative nature of the compliance results reviewed which is currently underway.

CQC Corporate Status History

Corporate RAG History 2012/13 (Overall RAG Status)

Accountabilities	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Outcome 01: Respecting and involving people who use services *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 02: Consent to care and treatment *	A	A	A	A	A	A	A	A	A	A	A	A
Outcome 04: Care and welfare of people who use services *	A	A	A	A	A	A	A	A	A	G	G	G
Outcome 05: Meeting nutritional needs *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 06: Cooperating with other providers *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 07a: Safeguarding people who use services from abuse (ADULTS) *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 07b: Safeguarding people who use services from abuse (CHILDREN) *	A	A	A	A	A	A	A	A	A	A	A	G
Outcome 08: Cleanliness and infection control *	A	A	A	A	A	A	A	A	A	G	G	G
Outcome 09: Management of medicines *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 10: Safety and suitability of premises *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 11: Safety, availability and suitability of equipment *	A	A	A	A	A	A	A	A	A	A	A	A
Outcome 12: Requirements relating to workers *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 13: Staffing *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 14: Supporting workers *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 16: Assessing and monitoring the quality of service provision *	A	A	A	A	G	G	G	G	G	G	G	G
Outcome 17: Complaints *	G	G	G	G	G	G	G	G	G	G	G	G
Outcome 21: Records *	A	A	A	A	A	A	A	A	A	A	A	A

CQC Essential Standards Highlight Report

CQC Essential Standards (Corporate)		
Outcome 01: Respecting and involving people who use services *	**RAG: Status (Corporate Assessment) - Green**	**QRP Rating: Low Yellow**
Reporting Period: Dec/Jan 13	Date Submitted: 30/01/2013	
Outcome Owner	Debra Hickman	
Outcome Sponsor	Charlotte Hall	
Achievements	A task and finish group has been established to look at care planning and best practice which will meet fortnightly. The top 10 care plans have been agreed along with the formatting.	
Concerns	The current interpreting contract is up for review .	
Variances and Actions Taken	Interpreting has now been put on the Trust risk register due to contract review. Patient experience lead is currently undertaking a review of all interpreting requirements. Work ongoing to ensure appropriate patient information available ongoing review of care plans within Best Practice Wards - to be rolled out to all wards in future.	

Outcome 02: Consent to care and treatment *	**RAG: Status (Corporate Assessment) - Amber**	**QRP Rating: High Yellow**
Reporting Period: Dec/Jan 13	Date Submitted: 30/01/2013	
Outcome Owner	Charlotte Hall	
Outcome Sponsor	Mr Ian Badger	
Achievements	The Trust achieved level 2 for Standard 5 Criterion 2 - Patient information and consent and also Standard 5 Criterion 3 - Consent training. A new clinical lead has been appointed for consent	
Concerns	Although theTrust Achieved level 2 for 5.2 patient information and consent and 5.3 consent training, the live health record checks demonstrated non compliance related to general standards of record keeping including appropriately sign , date, time and printing of names within the health record.	
Variances and Actions Taken	Directorate Health record checks continue monthly and are reported via the NHSLA steering group. Actions for improvement have been identified including: - review of current policy - sending an executive summary of the delegated consnet / consnet audit results to directorates - review of audit criteria.	

Outcome 04: Care and welfare of people who use services *	**RAG: Status (Corporate Assessment) - Green**	**QRP Rating: High Yellow**
Reporting Period: Mar/Apr 13	Date Submitted: 18/04/2013	
Outcome Owner	Rose Baker	
Outcome Sponsor	Charlotte Hall	

Achievements	Following an on iste review of compliance in January 2013 CQC declared no further concerns with regadrs to this outcome. CQC Responsive Review action plan completed. Must screening tool is now on VitralPac. Monitoring of Matron KPI's show improved compliance of the MUST Screening tool Process now in place to review NHS Choices Comments and address as appropriate at local level. Information regarding how to raise a concern/ complaint now available in all clinical areas - posters and information within bedside folders / information leaflets. Posters in all ward entrances and throughout the hospital to give information about how to raise a complaint or concern.
Concerns	Following Inspection in July this outcome was found to be non compliant with moderate concerns due to important safety checks not always being effectively completed in some of the operating theatres.
Variances and Actions Taken	Effective completion of the WHO checklist is currently being monitored. A letter has been addressed to all consultants and the Healthcare Governance Manager (Q&S) is working with directorate to support modification of the checklist for their own use. Links and Members set to support with audit of non clinical audits. Weekly review in place from Sept of wards less than 75% compliance with late observations. Targeting wards in this category to improve with additional support from VitalPAC trainer. Current trend appears to be improving however need to target areas of poor performance

Outcome 05: Meeting nutritional needs *	**RAG: Status (Corporate Assessment) - Green**	**QRP Rating: High Green**
Reporting Period: Apr/May 13	Date Submitted: 23/05/2013	
Outcome Owner	Kathryn Robinson	
Outcome Sponsor	Charlotte Hall	
Achievements	Nursing nutrition metrics developed. More than 95% of patients are nutritionally screened on admission. Assurance provided regarding recipes for dishes on hospital menu - these now all meet nutritional standards. Menu coded and being reprinted. Patients offered snacks between meals.	
Concerns	1. Accuracy of MUST screening 2. Concerns around patients having the opportunity to make informed choice of meals from the menu - patients not being issued with menu on all wards. 3. Recent audit reveals - patients fast for extended periods prior to planned surgery.	
Variances and Actions Taken	1. Nutrition screening to go on to Vitalpac June 2013, this will reduce errors and improve timeliness of repeat screening. Training package and development. 2. New menu being printed. Work will be done with individual wards to promote distribution of menu to patients. 3. Procedures and patient education around perioperative fasting being reviewed.	

Outcome 06: Cooperating with other providers *	**RAG: Status (Corporate Assessment) - Green**	**QRP Rating: Low Yellow**
Reporting Period: Apr/May 13	Date Submitted: 30/05/2013	
Outcome Owner	Zena Young	
Outcome Sponsor	Charlotte Hall	
Achievements	The annual audit of discharge was conducted October 11 – September 12. The use of the correct discharge form has shown an improvement at 60% compared with previous report compliance of 25%. A discharge summary or letter was present in 84% of medical records compared with previous report compliance of 69%. 100% compliance was achieved with recording of signature, designation and date of the individual completing the form for obstetrics. Policy and checklist reviewed and revised April 2013. Updates awaiting approval by Policy Committee. A dedicated workstream relating to discharges has been established within the Creating Best Practice programme, the programme is overseen by the Chief Nursing Officer.	
Concerns	Monthly audits show that further improvements are still required with respect to full compliance with the discharge policy.	
Variances and Actions Taken	Process audits are to be included in the ward/dept KPI's which are reported monthly to executive. Neonatal discharge checklist devised and protocol to be developed to accompany checklist reflecting practice. Integrated Patient Flow Team reports progress and variance against plan to Patient Productivity Steering Group.	

Outcome 08: Cleanliness and infection control *	RAG: Status (Corporate Assessment) - Green	QRP Rating: Low Green
Reporting Period: Apr/May 13	Date Submitted: 15/05/2013	
Outcome Owner	Vanessa Whatley	
Outcome Sponsor	Mike Cooper	
Achievements	A full review of the hygiene code has provided additional assurances for achieving compliance against Outcome 8.	
Concerns	Waste management requires assurances feeding into Hygiene Code	
Variances and Actions Taken		

Outcome 09: Management of medicines *	RAG: Status (Corporate Assessment) - Green	QRP Rating: High Yellow
Reporting Period: Mar/Apr 12	Date Submitted: 05/04/2012	
Outcome Owner	Fiona McKean	
Outcome Sponsor	Ray Fitzpatrick	
Achievements	For the directorate reports most are in date and accurate.	
Concerns	No evidence is present for Obstetrics. Inaccurate information is present in the section for EAU as they do not yet have a Mediwell 365. Although directorates and divisions are showing compliance there is a coporate action outstanding.This relates to the percentage of patients who stated that they were not told about side-effects of new medication at invitation and for continuation at discharge. This has been a CQUIN for the Trust for 2011/12.. An audit has been carried out for quarter 2 and a repeat audit during quarter 4 is still being completed.	
Variances and Actions Taken	Osbtetrics lead needs to be informed and this section needs to be completed. EAU lead to ensure accuracy of statement In order to address the lack of information on side-effects issue it will be ensured that all patient information leaflets are not separated from patient packs at the point of dispensing. A publicity campaigns which addresses both medicines adherence and information on side-effects of medication was carried out during July 2011. Leaflets have been prepared for patients which explains the role of the pharmacy team at ward level and encourages them to ask questions about their medications. This will be supplemented by a questionnaire on the effectiveness of this information. This information requires approval by the patient information leaflet committee.	

Outcome 10: Safety and suitability of premises *	RAG: Status (Corporate Assessment) - Green	QRP Rating: Low Green
Reporting Period: Mar/Apr 13	Date Submitted: 18/04/2013	
Outcome Owner	Carolyn Robinson	
Outcome Sponsor	Mike Goodwin	
Achievements	TEST 18.04.2013 Key stakeholders have completed a full review of theCQC outcome and will continue to monitor via a 4 monthly scrutiny meeting.. during review work has started to identify the metrics currentl in place which can support the monitoring of sustained compliance.	
Concerns	There are some gaps in assurance around directorate compliance of this ouctome due to the quality of information entered onto Health Assure.	
Variances and Actions Taken	The scrutiny group will continue to identify the metrics required to determine a level of assurance accross the Trust and will continue to monitor compliance 4 monthly.	

Outcome 11: Safety, availability and suitability of equipment *	RAG: Status (Corporate Assessment) - Amber	QRP Rating: Low Green

Reporting Period: May/Jun 13	Date Submitted: 04/06/2013	
Outcome Owner	Roger Moore	
Outcome Sponsor	Robert Millard	
Achievements	To date the following device types have been SafeHands tagged; pressure relieving mattresses, Colleague infusion pumps, defibs, T34 ambulatory syringe drivers, Hospira Plum infusion pumps and an ongoing programme for hospital beds. Phase 2 of Trust wide medical device audit is complete including data analysis. Report details in excess of 10,000 devices unaccounted for. Formal report to be distributed to Chief Nurse and Divisional Managers. Q1 2013 Medical Device Report and 2012 High Risk Device Audit report approved by Medical Devices Group.	
Concerns	Lack of resources for Medical Device Training is a concern as a result of rejection of funding for additional Medical Device Trainer. Potential issue relating to 'Failure of Device/Equipment' being reported to MPCE via Datix system. Continued lack of Divisional representation at Medical Devices Group meetings. Based on Divisional responses there appears to be concerns over storage facilities and security of medical devices and access to Pressure Relieving Mattresses. Continued degree of uncertainty with regards to compliance at Directorate level due to quantity and quality of information provided within PA at Directorate level within self assessment reports. It would appear that Directorates are not updating the reports potentially resulting in information gaps within the Directorate Compliance Reports. There is a discrepancy between the Divisions with regards to scoring, however issues were similar for both Divisions. Continued non-compliance and non-engagement from various areas has been noted with regards to the Medical Devices Audit. Non-compliances will be reported to Medical Devices Group, NHSLA Project Group and Health and Safety Steering Group. There is continuing concern with regards to wards/departments not using the online Medical Devices Helpdesk to report devices issues, this is a breach of HS11. CERL are facing difficulties when attempting to recover equipment as wards/depts are not releasing equipment for return after use, this is impacting on availability of stock.	
Variances and Actions Taken	Lack of Medical Device Training resource is to be monitored in line with Risk Management policies. Lack of Divisional attendance has been raised as an issue through Trust Governance Dept. Directorates to ensure that the following actions are taken without further delay: - Divisions to review suggested evidence and ensure that this is met at local level. - Explore differences in Divisional scores. - Directorate areas need to escalate storage issues through local governance risk assessment process. Ongoing SafeHands tagging of medical devices. Concern with regards to lack of Helpdesk usage has been communicated to Governance. Trust wide bulletin and attendance at future Senior Nurse meeting to be used to reinforce need to	

Outcome 12: Requirements relating to workers *	**RAG: Status (Corporate Assessment) - Green**	**QRP Rating: Low Yellow**
Reporting Period: Mar/Apr 13	Date Submitted: 12/04/2013	
Outcome Owner	Julie shillingford	
Outcome Sponsor	Diane Wilding	
Achievements	Reviewed evidence against standards, update to include results from 2012 Chatback and Staff Survey.	
Concerns	Following NHSLA audit, concerns around employment checks not being carried out for all temporary workers; medical staffing and nursing are the main areas of concern.	
Variances and Actions Taken	Concerns have been discussed with Divisional Medical Directors and Deputy Chief Operations Officers, policy has been revised to address concerns. Further audit was carreid out in September 2012, showing complaince still below target. Action plan has been put in place to improve compliance.	

Outcome 13: Staffing *	**RAG: Status (Corporate Assessment) - Green**	**QRP Rating: Low Yellow**
Reporting Period: Jan/Feb 13	Date Submitted: 28/02/2013	
Outcome Owner	Julie shillingford	
Outcome Sponsor	Diane Wilding	
Achievements	Review of evidence undertaken, no new information this time. HR Governance group is monitoring this standard.	
Concerns	There are no current concerns against this outcome.	
Variances and Actions Taken	No actions required	

Outcome 14: Supporting workers *	RAG: Status (Corporate Assessment) - Green	QRP Rating: Low Yellow
Reporting Period: Apr/May 13	Date Submitted: 23/05/2013	
Outcome Owner	Zoe Marsh	
Outcome Sponsor	Louise Nickell	
Achievements		
Concerns	Training topics with <95% compliance: RCA Manual Handling - People Antimicrobial Local Induction Blood Transfusion	
Variances and Actions Taken	Being monitored through the IMTG, NHSLA Project Group, and Project Board. Actions In place: Assurance is being sought from Directorates/Divisions where compliance with these topics is below the required threshold. Topics to be included in the Matrons KPI Reports (where they aren't already included).	

Outcome 16: Assessing and monitoring the quality of service provision *	RAG: Status (Corporate Assessment) - Green	QRP Rating: Low Yellow
Reporting Period: Mar/Apr 13	Date Submitted: 18/04/2013	
Outcome Owner	Kerry Walters	
Outcome Sponsor	Charlotte Hall	
Achievements	Complaince for this outcome is supported by NHSLA evidence . The trust acheived level 2 for Standard 1. governance in November 2012 and work is ongoing to achieve level 3 in September 2013	
Concerns	CQC Inspection July 2012 judged the trust as non complaint with minor concerns for this outcome and concerns are linked to those for outcome 4 - around effective completion of the WHO checklist in theatres. Gaps in assurance around monitoring systems / regular audits of process and learning lessons from incidents had not been fully embedded across all theatres	
Variances and Actions Taken	- CQC Action plan developed in response to the unannounced inspection in July. - Directorate to complete the list of procedures that require a modified safer surgical checklist (across all specialities including outpatients) - compliance with modified checklists in ambulatory settings to be reported. All wards and departments have a regular formalised patient feedback mechanism and that results are discussed and documented at ward/departmental meetings.	

Outcome 17: Complaints *	RAG: Status (Corporate Assessment) - Green	QRP Rating: Low Yellow
Reporting Period: Mar/Apr 13	Date Submitted: 23/04/2013	
Outcome Owner	Jamie Emery	
Outcome Sponsor	Charlotte Hall	
Achievements	Postcard sized stickers have been placed on each bedside locker giving patients information about PALS and raising a complaint. PET Tracker results are e mailed to Ward manager, Matron and Directorate manager on a monthly basis. Posters are now displayed at the entrance of all wards and through out the hospital giving information about about raising a complaint / concern. - A single centralised approach to processing complaints is in place.	
Concerns	We are not confident that signposting to CQC is adequate. Following CQC review patients lack information about how to complain In terms of divisional compliance there appears to be gaps in assurance for monitoring and closing action plans	

Variances and Actions Taken	Review of literature and information passed to complainants. Action plan in place to address CQC areas of concern including raising awareness of complaints process Divisions need to review the monitoring processes for action plans Divisional teams need to ensure that directorate are aware that the complaints process is applicable to everybody

Outcome 21: Records *	**RAG: Status (Corporate Assessment) - Amber**	**QRP Rating: Low Yellow**
Reporting Period: Apr/May 13	Date Submitted: 24/05/2013	
Outcome Owner	Lisa Myatt	
Outcome Sponsor	Chris Wanley	
Achievements	The destruction of microfilm reels has commenced in April 2013, and the cataloguing of the remaining reels is currently being undertaken. Costs are being sought to transfer teh remaining microfilms onto another media but the costs may be prohibitive Circa 4000 boxes (as at end of April 2013) are held at an off-site storage facility. No further storage is being sent off site. A facility has been set up at New Cross for all community records and the longest retenention dates from the off-site storage are due to be repatriated by September 2013. Acheived NHSLA assessmnet for Standrad 1 Criterion 7 - Health Records Management. Basic Record Keeping Standards Training Compliance has now reached 96.38% (against a target of 95%) as at the end of April 2013. Divisions 1 and 2 as well as Corporate Division are all acheiving over 95%	
Concerns	Did not demonsrate compliance with NHSLA Standards 1 Criterion 8 - Health record- keeping standards Non- complaince of NHSLA were due to failures with the live health records check.	
Variances and Actions Taken	Live health record checks continue at directortae level - a minimum of 30 sets of records a month are being audited by directorate staff - This is being monitired via divisional managment and NHSLA Project Board.	