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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO THE BOARD OF DIRECTORS' MEETING

HELD ON 20 JUNE 2012

Subject	Healthcare Governance Report
Supporting TEG Member	Professor Mike Richmond, Medical Director
Author	Sandi Carman, Head of Patient and Healthcare Governance
Status[1]	Note

PURPOSE OF THE REPORT

To update the Board of Directors on aspects of Healthcare Governance recently reviewed by the Trust, outline the current position and where appropriate provide an update on performance.

KEY POINTS

This summary aims to provide the Board of Directors with an overview of the significant Healthcare Governance matters reviewed by the Trust over the last month, these include:

1. Care Quality Commission Compliance
2. Medical Equipment Management
3. National Institute of Clinical Excellence (NICE) Implementation
4. Complaints and Feedback

The Trust has in place an annual Healthcare Governance work plan that ensures regular review of all aspects of Governance and covers the essential requirements of the Care Quality Commission and NHS Litigation Authority.

IMPLICATIONS[2]

	Aim of the STHFT Corporate Strategy 2012-2017	Tick as Appropriate
1	Deliver the best clinical outcomes	✓
2	Provide Patient Centered Care	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Deliver Excellent Research, Education & Innovation	

RECOMMENDATIONS

The Board of Directors are asked to note the contents of this report.

APPROVAL PROCESS

Meeting	Presented	Approved	Date
TEG	Mike Richmond		13 June 2012
BoD	Mike Richmond		20 June 2012

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the three pillars (aims) of the STH Corporate Strategy 2008-2012

1. CARE QUALITY COMMISSION (CQC) COMPLIANCE

Following the unannounced review of the Termination of Pregnancy regulated activity at the Hallamshire Hospital on 21 March 2012 the Trust have now received the final report from CQC (Appendix A). CQC reviewed a selection of case notes to ensure that the appropriate legal grounds for termination of pregnancy are met. In all cases the Trust was found to be fully compliant, no concerns were raised and no action plan is required.

The Trust reviewed the CQC Quality and Risk Profiles provided for April 2012 and confirmed that any areas for improvement were being addressed through workstreams with Executive leads.

As part of a continuous process of monitoring the internal CQC Compliance Review Group reviewed Trust wide provider compliance assessments for two CQC Essential Standards of Quality and Safety.

2. MEDICAL EQUIPMENT MANAGEMENT

Medical Equipment Management Group (MEMG) Terms of Reference and membership have been updated and this further clarified the links with other Committees of the Trust.

The revised Terms of Reference for MEMG extend the remit to provide support and management to the major medical equipment programme. MEMG will support the development of the three year rolling programme approach. The Medical Equipment User Training sub group of MEMG has played a key role in identifying any issues associated with user training. Training requirements associated with new equipment is now integrated within the implementation project, user training days are in place and the contents are regularly reviewed.

The planned replacement programme continues to be the main stay of the MEMG Capital Programme, in addition a new programme for flexible endoscopes had been initiated to support the development of the Endoscopy reprocessing business case, and the theatre lights replacement programme has been adopted by MEMG. These programmes give critical structure to identifying and managing requirements over future years.

Future priorities for the MEMG group include, ensuring the ongoing development of effective links with Capital Investment Team, maintaining the investment in medical equipment, ensuring that all training records are appropriately maintained, ensuring incidents are reported effectively and strengthening the governance arrangements for ensuring that all loan equipment is appropriately managed across the organisation.

3. NICE GUIDANCE IMPLEMENTATION

The Trust reviewed its position in relation to published NICE guidance (ie Technology Appraisals, Clinical Guidelines and the newly published Quality Standards). The implementation and compliance with NICE guidance is monitored internally by the NICE Implementation Steering Group and overseen by the Clinical Effectiveness Committee. Externally NICE implementation is monitored by NHS Sheffield and compliance with NICE guidance is expected by the CQC.

The Trust has a good track record of working towards full compliance with NICE guidance and clinical engagement with the process has further been encouraged by the NICE Implementation Steering Group. The NICE Implementation Steering Group has successfully managed all guidance referred to the group during the financial year 2011/2012 (22).

The Trust processes have being audited by NHS Assure (Internal Auditors) and received a 'B' rating signifying significant assurance that there is good internal control of the process of managing NICE guidance.

Clinical areas are very aware of the Quality Standards and their potential for Commissioners in the future. All NICE quality standards have an implementation lead and where possible these are being implemented into practice. All quality standards are carefully monitored to ensure continued progress and enable the Trust to embed the requirements into practice.

4. COMPLAINTS AND FEEDBACK REPORT MARCH 2012

The number of complaints received in March is consistent with the average number received per month over the past year (118). The March Complaints and Feedback information was discussed and actions agreed at the Patient Experience Committee on 30 April 2012. Further detail and analysis of complaints during 2011/2012 will be undertaken as part of the Trust's annual complaints review.

No specific in-patient areas showed peaks in the number of complaints received. In outpatients three areas received more complaints than anticipated. These predominately related to medical staff (for example, their approach), diagnosis and treatments, waiting times and delays.

The Trust performance for compliance with complaints within 25 working days was 89% in March which is a substantial improvement on previous months. The improved performance is primarily related to significant improvement to response time within the Surgical Service Care Group. The challenge for the Surgical Services team is now to sustain this improvement.

APPENDIX A

Sheffield Teaching Hospitals NHS Foundation Trust Royal Hallamshire Hospital	
Region:	Yorkshire & Humberside
Location address:	Glossop Road Sheffield South Yorkshire S10 2JF
Type of service:	Acute services with overnight beds Community healthcare service Rehabilitation services
Date of Publication:	May 2012
Overview of the service:	The Royal Hallamshire hospital is an NHS hospital that provides termination of pregnancy services.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Royal Hallamshire Hospital was meeting all the essential standards of quality and safety.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 21 March 2012.

What people told us

This review is part of a targeted inspection programme to services that provide the regulated activity of terminations of pregnancy. The focus of our visit was to assess the use of the forms that are used to certify the grounds under which a termination of pregnancy may lawfully take place.

We did not speak to people who used this service as part of this review. We looked at a random sample of medical records. This was to check that current practice ensured that no treatment for the termination of pregnancy was commenced unless two certificated opinions from doctors had been obtained.

What we found about the standards we reviewed and how well Royal Hallamshire Hospital was meeting them

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

We found that the registered provider met the part of the regulation which was the subject of this review in relation to the maintenance of HSA1 forms.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 21: Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not speak with people who used the service as part of this review.

Other evidence
Section 1 (1) of the Abortion Act 1967 (as amended) and the Abortion Regulations 1991 (as amended) require that two doctors provide a certificated opinion, formed in good faith, that at least one and the same ground for a termination of pregnancy as set out in the Act, is met.

These opinions have to be given in a certificated form as set out in the Regulations and must be given before the commencement of the treatment for the termination of pregnancy, except in the specified circumstances set out in the Act.

One of the ways in which the Regulations provide for doctors to certify this opinion is in an HSA1 form. If using the HSA1 form, both of the certifying doctors must complete the form as required and sign and date the certificate. The opinion of each doctor is required to relate to the circumstances of the individual person's case.

During our visit, we looked at a random sample of medical records for fifteen people who had undergone a termination of pregnancy at The Royal Hallamshire Hospital. The records were for procedures that had all taken place within the preceding month. In each case, we looked at the certificate completed and the other records for that person.

We found that in all of these records, doctors' certifications were being accurately and appropriately maintained.

Our judgement
We found that the registered provider met the part of the regulation which was the subject of this review in relation to the maintenance of HSA1 forms.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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Care Quality Commission

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