UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 28 July 2016

Title:	**QUARTER 1 COMPLIANCE AND ASSURANCE REPORT**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Bob Hibberd, Head of Clinical Risk and Compliance Louisa Sorrell, Senior Manager Clinical Compliance

Purpose:	To present an update to the Audit Committee of the internal and external assurance processes.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	• The CQC carried out a focused inspection in relation to cardiac surgery on 21 and 22 December. The two conditions that were imposed on the Trust, as a result of the visit, have been removed. It was noted that the data and information submitted demonstrated improvements had been made in the service which has reduced the risk of harm to patients. • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 76% of cases (improvement form 71% in Q4). • There were 10 external visits in quarter 1. • Compliance for quarterly review of risk registers is 95.6%	
Recommendations:	The Audit Committee is asked to accept the report.	
Approved by:	D Burbridge	Date: 19 July 2016

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 28 JULY 2015

QUARTER 1 COMPLIANCE AND ASSURANCE 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 June 2016.

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 Announced Inspection

The CQC carried out an announced inspection of the Trust in January 2015 and published its findings in May 2015. The Trust was assessed as being fully compliant with the CQC essential standards. However the CQC did highlight some areas of weakness and these have formed part of an action plan which is monitored by the Director of Corporate Affairs Governance Group. There is 1 action which has not been fully implemented; details of the action plan are contained within Appendix A.

2.1.3 Focused Inspection

a) The CQC carried out a focused inspection relating to cardiac surgery on the 21 and 22 December 2015. The visit was triggered by the release of data in September 2015 by the National Institute for Cardiovascular Outcomes Research suggesting that the Trust is an outlier in terms of mortality. During September 2015 the Trust had established, before any notification from the CQC, a Cardiac Surgical Quality Improvement Program (CSQIP).

(b) Following the inspection, the CQC placed the following 2 conditions on the Trust's registration with the CQC:

(i) the Trust is required to commission an external review of the

service and this was due to be completed by 31 March 2016; and

(ii) the Trust is required to submit weekly outcome data to the CQC every Wednesday.

c) Since the 2015/16 quarter 4 report the Trust has responded to the recommendations from both the CQC's and external reviewer's reports. Whilst the majority of the actions in response to the recommendations were already being progressed through the CSQIP, the additional actions identified have been added to the project plan.

d) On the 25 May 2016, the Trust received notification from the CQC that the above two conditions are removed from the Trust's registration and noted that the data and information submitted demonstrated improvements had been made in the service which has reduced the risk of harm to patients. The CQC advised that the data still demonstrated some variation and requested that the Trust continues to submit the monitoring data on a quarterly basis. The Trust will be submitting an update on the clinical outcome data and the actions in response to the CQC's and external reviewer's recommendations during July 2016.

e) The Cardiac Surgery Quality Improvement Programme (CSQIP) project plan continues. The project plan is monitored on a weekly basis by the project group and reports on progress against the project plan are provided to the Cardiac Surgery Steering Group and the Cardiac Surgery Oversight Group.

2.1.4 Review of Compliance Framework

The existing compliance framework has been reviewed in light of the recent CQC inspection into cardiac surgery. Based on the review the following changes are being made:

a) The measures contained within the existing framework are being refreshed to ensure some 'softer measures' are captured e.g. does a speciality review outcome data, do mortality and morbidity meetings take place etc. The measures that we will be using are largely based on the questions peer reviewers, ISAS/IQIPS accreditors and the CQC ask.

b) The new compliance framework is being piloted in renal medicine and liver surgery. Following completion of the pilot (August 2016) the final version will be rolled out across all divisions.

2.2 NICE

2.2.1 The Trust either meets all recommendations, or is working towards meeting all recommendations, in 76% of cases. In 12% of cases, the guidance is under review by a senior clinician. In 11 % of cases the Risk and Compliance Unit are awaiting a response from the Guidance Lead. In 1% of cases there is a divergence against NICE recommendations.

2.2.2 Overdue responses are highlighted at Specialty meetings and the Divisional Clinical Quality Group (DCQG) meetings. The Divisional follow-up follow up all overdue responses with the individuals.

Figure 1: Breakdown of non- compliance with NICE guidance by Division

Non-Compliant	Partially Compliant	Overdue Response	Under Review / Working towards compliance
Division A			
0	**1**	**1**	**15**
Division B			
2 Not Compliant and approved 2-Awaiting decision from the Divisional Director followed by CQMG-Email sent.	**0**	**11**	**19**
Division C			
2	**1**	**10**	**23**
Division D			
0	**0**	**9**	**29**

Trust Compliance with External Visits/Peer Reviews

2.3 The Trust has a process in place to ensure the appropriate coordination and evaluations of external recommendations arising from external agency visits, inspections, accreditations and peer review/assessment.

2.4 Except for the CQC visits see section, above, the table below contains full details of the outcome of the visits that took place in Q1 2016/17. It also includes details of the Environmental Agency visit to Pharmacy that took place in quarter 4 2015/16 as the outcome of this visits was unknown at the time of reporting.

Inspecting Organisation	Area being inspected	Date of Visit	Outcome of Visit	Assurance Level
Environmental Agency	Pharmacy	1st March 2016	The visit was made in response to notification of an incident involving the loss of radioactive material. The incident was initially notified to the Environment Agency on 18 February 2016 The incident concerned the loss of approximately 26 MBq of Chromium-51 in 1 ml of aqueous solution, in a glass vial within an orange container, inside several layers of packaging. They found 3 breaches in the Environmental Permitting Regulations and identified actions the Trust should take. At present, the EA does not intend to take further enforcement action.	No action plan received from lead, escalated to divisional management for a response which will be included in the Q2 report.
Centre for International Blood and Transplant Research (CIBMTR)	Clinical Haematology	4th April 2016	Centre failed the data quality audit with a critical field error rate of 4.7% (3% or lower required to pass).	Awaiting action plan from lead due to be completed in August 2016 and to be included in Q2 report
Specialised Commissioning Review of Renal Transplant Services	Renal Services	4th April 2016	This was in the form of a meeting following publication of the annual report on Kidney Transplantation published in September 2015. No actions from this meeting - there is an ongoing action plan from September 2015. All immediate actions have been completed from this. There are a few long-term ongoing actions.	Positive
Health Education England West Midlands	Medical Education / Cardiothoracic Surgery	22nd April 2016	This was an urgent and exceptional level 3 review of Cardiothoracic Surgery training following concerns identified during the recent CQC inspection. Still awaiting report but notes were taken on the day - training programme approved. No action plan or progress report required. Revisit in 12 months.	Positive
National Cancer Peer Review Programme (NHS England)	Cancer Services	5th May 2016	Weaknesses highlighted in Head and Neck MDT and CUP. An action plan has been put in place to address the weaknesses identified which is monitored through the monthly Cancer Steering Group.	Neutral
Health & Safety Executive	Maxillofacial Labs and Stores	6th May 2016	This inspection was due to the diagnosed Occupational Asthma of a Restorative Dentist who works in a room in UHB OPD clinic. The HSE visit is being conducted jointly between UHB and the Dental hospital and has not yet been concluded. To date, no further action has been taken by the HSE in respect of the Trust.	TBC

Health & Safety Executive	Health and Safety	17th May 2016	Following the original HSE visit on 26th January 2016 regarding safer sharps, a follow-up visit took place on 19th May 2016. To date, no further action has been taken by the HSE in respect of safer sharps following the second visit.	Positive
West Midlands Breast Screening Quality Assurance	Breast Care	14th June 2016	Awaiting report – TBC in Q2 2016/17	TBC
Department of Health - Vascular Clinical Quality & Efficiency Programme	Vascular Surgery	21st June 2016	Awaiting report – TBC in Q2 2016/17	TBC
NSHCS accreditation visit for STP training in Neurophysiology	Neurophysiology	22nd June 2016	Awaiting report – TBC in Q2 2016/17	TBC

3. Outcome of Audits

3.1 National Audits:

3.1.1 The Trust is currently either participating in or scheduled to participate in 32/34 National Audits listed on the HQIP Quality Accounts. 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.

3.1.2 Of these 34 mandatory National Audits listed on the Quality Accounts, 8 are new for 2016/17:

(a) Six of these were already underway at UHB as they were part of the Consultant Outcomes Publication Programme and a requirement for clinicians to participate in for membership with their Royal Societies.

(b) The two that are new are the Learning Disability Mortality Review Programme and the National COPD Audit, which had previously run as a snapshot audit but will be moving to continuous data collection in 2016/17.

3.1.3 The Risk and Compliance Unit have completed a review of the national audits and details of the outcome of the review were presented at the Clinical Quality Monitoring Group (CQMG) in November 2015. The Group agreed the following programme of work should be completed by in

order improve the national audit process:

(a) Review staff resource and workload across all divisions for national audit. Based on current model, exception to Div D, some specialties have an audit lead that is or is not fully utilised for audit work and other specialties do not have any resource. The review will aim to look to see if a pool of audit resources would be better and cost effective. This piece of work is due to completed at the end of April 2016.

(b) Implementation of a robust data validation processes

(c) Improved monitoring from risk and compliance including monitoring of actions from national audit reports. This has been implemented and from 2016/17 reports on outcomes form national audits will be reported at speciality meetings.

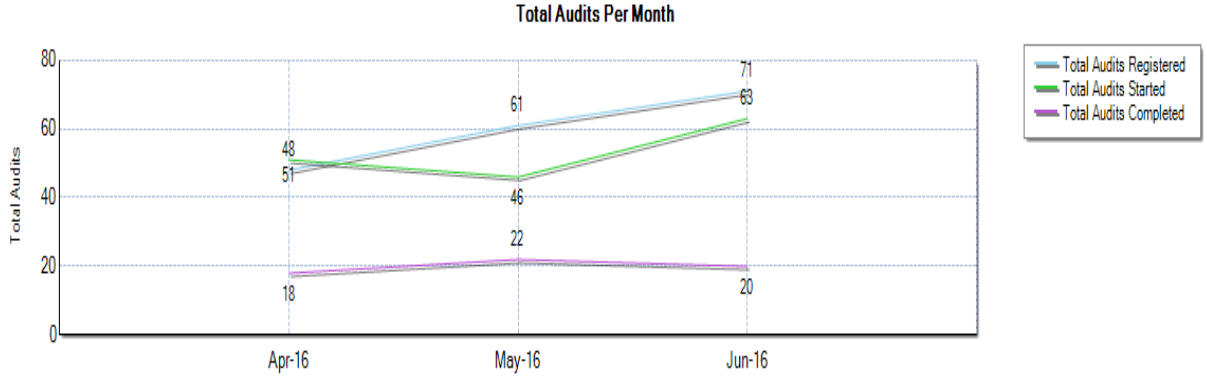
(d) Cancer Group Audits – there are issues with data submission for all cancer group audits, with the exception of the National Lung Cancer Audit. The main issue is uncertainty over where the responsibility for completing these audits lies (ie Division or Cancer Services). This is complicated by the presence of other datasets that overlap with the audit datasets and the current process by which pathology produce their reports (free text which requires interpretation to input to Somerset). This is being addressed by increased Risk & Compliance involvement with the Cancer Informatics Group with a view to establishing a process for which department submits which data, looking into the mechanism by which pathology produce their reports, and identifying any additional resource that may be required.

An update on all of the above actions is being presented to the CQMG in July 2016 and will be included in the Q2 2016/17 Board report.

3.2 <u>Local Audits:</u>

The table below provides an overview of the number of local audits registered on the Trust's Clinical Audit Registration & Management System (CARMS) within quarter 1.

Figure 2: Q1 16/17 Audit Activity



4. Risk Register Audit

4.1.1 Compliance for quarterly review of risk registers is as follows:

Target	Q1	Q2	Q3	Q4
95%	95.6%	-	-	-

4.1.2 Where there is no evidence that high and significant risks have been reviewed the Risk and Compliance Unit will liaise with the relevant management teams to ensure a quarterly review.

4.1.3 The audit will be repeated for Quarter 2, 2016-17 to ensure continued monitoring of compliance with the risk register process.

5. Recommendation

The Audit Committee is asked to accept this report.

David Burbridge **July 2016**
Director of Corporate Affairs