UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 27 OCTOBER 2016

Title:	**QUARTER 2 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 provide the Board of Directors with information regarding internal and external compliance as of 31 September 2016.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	• The new pilot for the new clinical compliance framework has been completed. • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 79% of cases (improvement from 76% in Q1). • There were 3 external visits in quarter 2. • Compliance for quarterly review of risk registers is 91.4%	
Recommendations:	The Board of Directors is asked to accept the report.	
Approved by:	D Burbridge	Date: 18 October 2016

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 27 OCTOBER 2016

QUARTER 2 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 31 September 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).

(a) Following the inspection, the CQC placed 2 conditions on the Trust's registration with the CQC which were subsequently removed on 25 May 2016.

(b) The Trust continues to provide a quarterly report to the CQC and NHS England which includes an update on progress against the CQC's and external reviewer's recommendations. The report also includes a quarterly analysis of the clinical outcome data. At the time of writing this report only 2 out of 62 actions remain outstanding and these continue to be monitored by the CSQIP steering group.

2.1.4 Outcome of Clinical Compliance Framework Pilot

(a) As advised in the quarter 1 report the existing compliance framework was reviewed in light of the recent CQC inspection into cardiac surgery and was amended to include speciality focused measures.

(b) There are 105 measures contained within the compliance framework across the following areas:

(i) Interaction with patients/family
(ii) Meeting patient's individual needs
(iii) Strategy for the service
(iv) Governance Structure
(v) Innovation
(vi) Service Planning
(vii) Access and flow
(viii) Evidence -based care
(ix) Clinical Outcome data
(x) Speciality Audit
(xi) Nutrition and Hydration
(xii) Pain Relief
(xiii) Multi-disciplinary working
(xiv) Admission, Handover & Discharge
(xv) Mortality and Morbidity
(xvi) Infection Control
(xvii) Record Keeping
(xviii) Incident Reporting and Complaints
(xix) Assessing Patients
(xx) Staff levels (nurse & theatres)
(xxi) Staff Levels (Medical)
(xxii) Staff competency (All)

(c) The pilot was carried out in renal medicine, liver surgery and neurosurgery. This involved the Clinical Service Lead, Group Manager and Matron completing a self-assessment against the measures. In all three areas the leads liaised with relevant staff for example the ward manager, doctors, and leads in other services who they work closely with. The self-assessment is currently being assessed by the Clinical Compliance Team by comparing the response to various performance, quality and audit data that is available across the Trust. The outcome of the Clinical Compliance Teams assessment will be fed back to the Divisional management teams and the specialities during November.

(d) Overall the feedback from the specialities was positive and when asked if they found the exercise useful, all specialities agreed that it was. The table below sets out the changes that have subsequently been made to the compliance framework based on feedback from the pilot:

Feedback	**Changes made (where required)**
Whilst one speciality felt that the time required to complete the self-assessment was adequate the other specialities felt that they needed longer.	We will extend the deadline from 4 weeks to 6 weeks to complete the self-assessment
For some measures the spreadsheet only allowed the speciality to insert 'yes' or 'No' and it was felt that it would be useful to be able to include additional comments	The framework has been updated to include these measures.
There were three measures where is was felt that two questions were being asked and that these should be separated	The framework has been updated to reflect this

(e) There were no measures identified as being incorrect or not required/relevant.

(f) The Framework will be rolled out across all specialities from November – January 2016 with the exception of the division A specialities as the measures need to be updated to so that they are more applicable to the specialities in division A.

(g) Once the compliance framework has been rolled out in division B, C and D a summary of the compliance levels for each division will be included in this report. In the interim compliance for each speciality will be monitored by the divisional management teams via the speciality meetings.

2.2 <u>NICE</u>

2.2.1 The Trust either meets all recommendations, or is working towards meeting all recommendations, in 79% of cases. In 8% 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 2% 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**	**12**
Division B			
2 Not Compliant and approved 1-Awaiting decision from the Divisional Director followed by CQMG-Email sent.	**0**	**10**	**12**
Division C			
1	**1**	**10**	**29**
Division D			
0	**0**	**12**	**31**

2.3 Trust Compliance with External Visits / Peer Reviews

2.3.1 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.

2.3.2 The table below contains full details of the outcome of the visits that took place in Q2 2016/17. It also includes details of the Environmental Agency visit to Pharmacy that took place in quarter 4 2015/16 and the following visits that took place in quarter 1 of which the outcome of the visits were unknown at the time of reporting for quarter 1: CIBMTR visit to haematology, WMBSQA visit to Breast Care, Department of Health visit to Vascular Surgery, NSHCS visit to Neurophysiology.

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 (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. All actions necessary to fulfil requirements of the report are now complete.	Positive
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). Action plan put in place to improve practise on the consent process and disease status and assessment data. CIBMTR are happy that actions are complete and will be issuing an audit certificate soon.	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. Actions due to be complete end of October 2016.	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.	Neutral
West Midlands Breast Screening Quality Assurance	Breast Care	14th June 2016	The review team identified no immediate concerns. In total there are 12 recommendations including 2 high priority issues. Responses to the 3 month recommendations (9) are requested by 13 December 2016 and responses to the 6 month recommendations (3) by 13 March 2017. The action plan is due to be presented to the Patient Safety Group in Q3 16/17.	Neutral
Department of Health - Vascular Clinical Quality & Efficiency Programme	Vascular Surgery	21st June 2016	A number of recommendations were made and an action plan is being developed to implement advised improvements.	Neutral
NSHCS accreditation visit for STP training in Neurophysiology	Neurophysiology	22nd June 2016	Accredited with conditions - to be actioned by 28/10/2016: 1. The panel recommend the department reflect on Patient and Public Involvement in order to ensure Patient Centred Care plays an important	Neutral

			part in of the training given 2. The panel recommend that competencies and assessments are more focused, to reduce the volume of evidence provided and thus reduce the burden on both trainee and assessor.	
NHS England Quality Surveillance Team (QST) - Peer Review Programme	Heart and Lung Transplant	June 2016	National Peer Review published. UHB compliant with 57% of measures. Awaiting local report – TBC in Q3 2016/17 report.	TBC
CCG - Clinical Commissioning Group	Renal Medicine	13th July 2016	Unannounced visit to ward 303. Overall the verbal feedback was very positive. Awaiting report – TBC in Q3 2016/17 report.	TBC
CCG - Clinical Commissioning Group	Liver, Upper GI and Colorectal	21st July 2016	Unannounced visit to wards 727 & 728. Awaiting report – TBC in Q3 2016/17 report.	TBC
UK Accreditation Scheme (UKAS)	Cellular Pathology ISO15189		TBA	TBA

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.
(i) The Learning Disability and Mortality Review Programme is still in development and no updates have been received from the

national team since Q1.

(ii) The National COPD Audit pilot has completed, UHB has provided feedback to the national team and a scoping exercise is underway to identify likely data entry requirements and potential for automated data retrieval.

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) A review of staffing resources and national audit data requirements has been completed. Divisions A, C and D are currently appropriately resourced and discussions are being held with Division B management with regards to a pooling of resources in order to better meet the extensive data submission requirements within the division.

(b) The first in-house national audit data management system has started development for the Cardiology Audits in Div B. If this is successful it will be expanded to other suitable audits in due course.

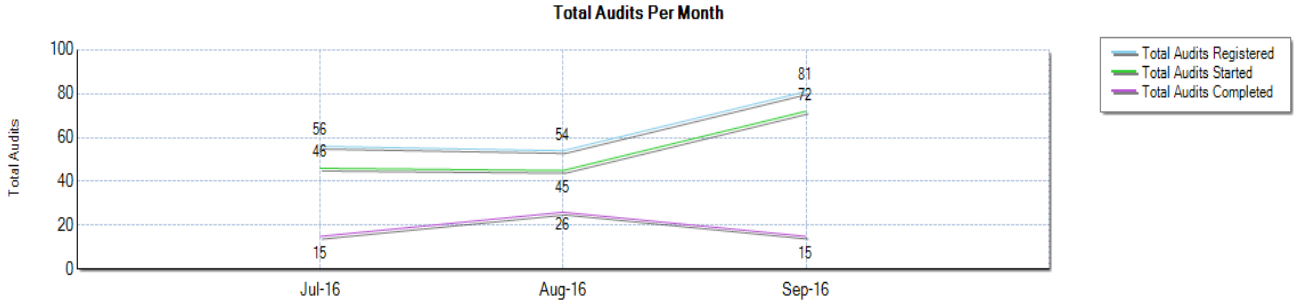
(c) The first outcomes of national audit reports have been reported to Divisional Clinical Quality Groups.

(d) Cancer Group Audits – The review of Cancer Data streams has been completed. The Cancer Outcomes and Services Dataset (COSD) submissions will be handled by Cancer Services and the national audit datasets by the relevant divisions. This lowers the requirements for data submission for both parties given the significant overlap in the datasets. Division D cancer audits have significantly improved submissions in recent months, and work on improving data submission for the Division B audits is being incorporated into the previously discussed work on national audits within the division.

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 2. Figure 2 shows these figures compared to the previous quarter.

Figure 1: Q2 16/17 Audit Activity



Quarter	Month	Total Audits Registered	Total Audits Started	Total Audits Completed
1	April	48	55	18
	May	61	46	22
	June	71	65	20
2	July	56	46	15
	August	54	45	26
	September	81	72	15

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%	91.4%	-	-

4.1.2 The reason for the target not being met was due to a large proportion of speciality meetings being cancelled during August 2016.

4.1.3 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.

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

5. Recommendation

The Board of Directors is asked to accept this report.

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