UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 23 APRIL 2015

Title:	**QUARTER 4 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 Board of Directors of the internal and external assurance processes.	
Confidentiality Level & Reason:	None	
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	• The Trust is compliant with all CQC Essential Standards – based on CQC Assessment • The Trust is CQC risk rated at Band 5 of 6, with 1 being worst and 6 being the best. The Trust has not received the Q4 rating • The percentage of risk registers that were either compliant or partially compliant, when combined, was 96%. • There were 5 external inspections during Quarter 4.	
Recommendations:	The Board of Directors is asked to accept the report.	
Approved by:	D Burbridge	Date: 22 January 2015

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QUARTER 4 COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY DIRECTOR OF CORPORATE AFFAIRS

1. Purpose

This paper provides the Board with information regarding internal and external compliance as of 31 March 2015.

2. Internal Assurance

2.1 Care Quality Commission (CQC) Essential Standards of Quality and Safety

2.1.1 The Trust has a process in place to ensure assurance against the Essential Standards. Table 1 below is a review of the Trust position, internal and external assessment of compliance against Essential Standards.

Outcome	Internal Assessment	CQC External Assessment at last assessment	Explanation	Assurance
CQC Essential Standards Outcome 16: Assessing and Monitoring the Quality of Service Provision	Compliant	Compliant	**Date of inspection:** Unannounced inspection on 28 November 2014 to follow up on previous inspection 22-24 July 2013 **Outcomes:** CQC report deemed the Trust fully compliant: People were safe and benefited from appropriate arrangements to assess their needs and plan, provide and regularly review care and treatment that met their needs and protected their rights The provider had effective systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service.	Latest CQC inspection report. Internal processes to give BoD assurance on progress against standards and reduction of pressure ulcers. Internal pressure ulcer campaign. An audit of patients who require assistance whilst feeding is being undertaken monthly and reviewed at Care Quality Group.

Outcome	Internal Assessment	CQC External Assessment at last assessment	Explanation	Assurance
CQC Essential Standards Outcome 9: Medicines Management	Amber-Green	Compliant	Following annual audit for safe and secure medicine, actions to improve some aspects of management of medicines were identified. The issues were discussed at Safe Medicines Practice and the action plan presented at Clinical Quality Monitoring Group. The risks have been added to the Medical Director & Chief Nurse Executive risk registers. Further audit shows considerable improvement (see assurance column). However, as there remains insufficient assurance of overall compliance in a small number of specific areas, this Outcome 9 remains at partial compliance.	Further audits of compliance undertaken and ongoing audit to provide further assurance of improvements. ADNs providing specific focus on areas below standard. An outline business case to implement a medicines security system is being progressed. Internal audit has undertaken a review and identified where further improvements are required – underpinning Trust audit processes.

2.1.2 From 1 April 2015 the CQC are replacing the Essential Standards with the new Fundamental Standards. A gap analysis is being carried out by the Clinical Compliance team to identify any gaps in compliance with the new standards. Where gaps are identified the Senior Manager Clinical Compliance will work with the relevant leads to rectify this. The outcome of this review will be presented to the DCA Governance Group in May 2015 and then to Board.

2.2 Risk Register Audit

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

Target	Q1	Q2	Q3	Q4
95%	99%	87%	100%	96%

2.2.2 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.

2.2.3 The audit will be repeated for Quarter 1, 2015-16 to ensure continued monitoring of compliance with the risk register process. The Risk and Compliance Unit will continue to liaise with the owners of any risk registers that are non-compliant.

2.2.4 During Q1 2015/16 a review of the format of the risk registers and the process for escalating risks on to the relevant registers will be carried out and where improvements are identified these will be incorporated into the risk register policy

and procedure. The outcome of this work will be included in the Q1 2015/16 report

2.3 NICE Guidance

2.3.1 The Trust has a process in place to implement, review and record decisions where recommendations are not being met.

2.3.2 The Trust either meets all recommendations, or is working towards meeting all recommendations, in 77% of cases (previous quarter was 73%). In 11% of cases, the guidance is under review by a senior clinician. In 10% 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. Overdue responses are highlighted at Specialty meetings and are escalated to the Divisional Clinical Quality Group and / or the Clinical Standards Audit Group.

2.4 National Audit

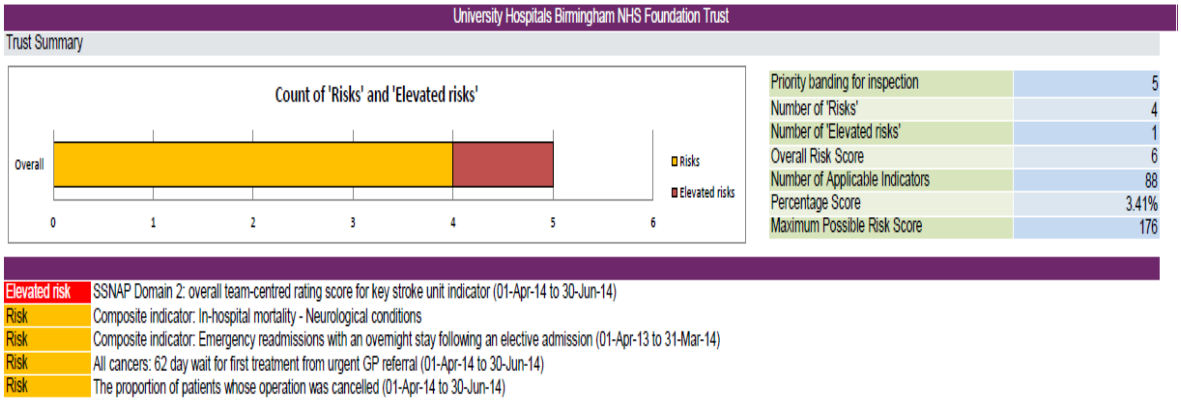
During 2014/15 UHB participated in 98.3% of the national clinical it was eligible to participate in. Non participation has been approved by the Medical Director via the Clinical Quality Monitoring Group. Two exceptions are as follows:

2.4.1 National Audit of Emergency Laparotomy (NELA)
Comparative cumulative figures detail UHB as having entered less than 50% of estimated cases for the 1st year of the audit. These figures have been reviewed and challenged by UHB as this number appears significantly higher than what is coded by the Informatics team. NELA have confirmed that the numbers are determined by using a 6 year average and that these are a very rough estimate which should not cause any concern. UHB are confident all applicable cases are included in the audit and this data is currently being verified and we have submitted 97% of cases. Plans are underway to allow access to the NELA website on the PCs in Theatres to allow immediate data entry.

2.4.2 ICNARC
For the 2014 data there was a significant backlog of cases that require data entry. As a consequence the Division reviewed the resources allocated and have commenced a dialogue with IT with regard to building an in-house database to populate electronically, which was discussed at the CQMG. The team are now working toward 100% compliance for the 2015 data upload with a rectification plan in place to complete the collection of the 2014 data which has been agreed with ICNARC.

3. External Assurance

3.1 The Trust has a process in place to ensure that intelligence monitoring data published by the CQC is reviewed and reported to the Director of Corporate Affairs, Medical Director and Executive Chief Nurse. The Trust was placed in Band 5 of 6 with 1 being the worst and 6 being the best for Q3. There has been a delay in receiving the Q4 Intelligence Monitoring Report (IMR) from the CQC, which is now planned to be released on 28 April 2015.



The methodology continues to be adapted by the CQC.

3.2 External Visits

The Trust has a process in place to ensure the appropriate co-ordination and evaluations of external recommendations arising from external agency visits, inspections, accreditations and peer review/assessment. In Quarter 4 the Risk and Compliance Unit were notified of 4 visits by external organisations with one action plan outstanding. Full details of the outcome of the visits are below:

Inspecting Organisation	Area being inspected	Date of Visit	Outcome of Visit	Assurance Level
Health & Safety Executive	Microbiology Cat 3 area	10 December 2014	It was agreed in the Q3 Compliance report that an update would be provided on the outcome of this visit as the report was not available at the time of writing the Q3 report. Overall the inspection did not raise any significant concerns but the HSE did make the following two recommendations: 1. Greater clarity on maintenance schedules and access by staff and contractors is required between Cofely and UHB lab staff. 2. Scenarios need to be instigated to test spillage procedures prior to TB work being repatriated and continued after, alarm bell needs installing between the Control 3 rooms and the main lab prior to TB work being repatriated The Quality Manager is currently implementing the recommendations	Amber-Green
Medicines and Healthcare Regulatory Authority (MHRA)	GSK sponsored clinical trials within R&D	07 January 2015	The inspection was part of a six month inspection by the MHRA of GSK, and we were selected as a site who GSK acted as sponsor for one of their Phase 2 clinical trials. The inspectors gave verbal feedback at the end of the inspection. Senior members of the R&D team, Jo Plumb and Shahnaz Gill	TBC

Inspecting Organisation	Area being inspected	Date of Visit	Outcome of Visit	Assurance Level
			Stokes were in attendance. GSK are anticipating that the report will be due at the end of April. Following receipt of the report an update will be provided in the Quarter 1 2015/16 Compliance Report	
Care Quality Commission	Announced inspection of Core Essential Standards	28 – 30th January 2015	There were no significant concerns raised by the CQC during their feedback session to the Executive team on 30 January 2015. At the time of writing this report the outcome of the inspection is unknown. An update will be provided in the Quarter 1 2015/16 Compliance Report	TBC
Health and Safety Executive (HSE)	Pathology	28 January 2015	The HSE have only given a verbal report at the time of the inspection. A written report is only provided if any issues are highlighted. The visit was positive with no concerns raised.	Positive
NHS England – National Peer Review Team	Major Trauma Service Peer Review	18 March 2015	NHS England have raised 4 concerns which they believe do not present 'an immediate risk to patient or staff safety, but is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve'. The final report from NHS England is due to be submitted within 8 weeks of the inspection. In response to the 4 concerns raised, the Professor of Clinical Traumatology and the Divisional management team have identified relevant mitigation actions and these were presented at the Chief Operating Officers Group. An update on progress with these actions and the outcome of the report will be contained in the Q1 2015/16 report.	Amber
UKAS	Biochemistry Department	11th March – 13th March 2015	The assessors complemented the Trust on our facilities and the service we provided. The Trust was given 37 Non-conformances against the ISO 15189 standards and CPA standards, all of which were graded as non-critical. The Trust has until 17 May to provide evidence to clear 17 of the non-conformances and until 5 June to clear the remaining 20.	Amber-Green

4. **Recommendation**

The Board of Directors is asked to accept this report.

David Burbridge **April 2015**
Director of Corporate Affairs