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

Title:	**QUARTER 3 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 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. • The CQC carried out a focused inspection in relation to cardiac surgery on 21 and 22 December. Two conditions have been imposed on the Trust as a result of the visit • The Trust either meets all NICE recommendations, or is working towards meeting all the recommendations, in 76% of cases. • There were 5 external visits in quarter 3. • Compliance for quarterly review of risk registers is 93%	
Recommendations:	The Board of Directors is asked to accept the report.	
Approved by:	D Burbridge	Date: 21 January 2016

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

BOARD OF DIRECTORS

THURSDAY 22 OCTOBER 2015

QUARTER 3 COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY DIRECTOR OF CORPORATE AFFAIRS

1. Purpose

1.1 The purpose of this paper is to provide the Board with information regarding internal and external compliance as of 31 December 2015.

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 are 2 actions which have not been fully implemented yet, details of the action plan are contained within Appendix A.

2.1.3 Focused Inspection

(a) The Trust was given 1 week's notice that the CQC were going to carry 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. This data relates to the three year period from 2011 to 2014 and, as previously discussed at the BOD, contains data relating to two surgeons who no longer work at UHB (and whose data is not published against their names) and does not include 132 patients operated on by UHB teams at the Priory with no deaths. No current surgeons at the Trust are mortality outliers.

(b) Whilst the Trust has reservations about the data which triggered the inspection, we do accept that significant improvement could be made to cardiac surgical services at the Trust. Indeed, the Trust had already established in the autumn of 2015, before any notification from the CQC, a Cardiac Surgical Quality Improvement Program (CSQIP). The Trust is working with the CQC to ensure that the concerns raised by the internal CSQIP and those identified by the visit are addressed as expeditiously as possible using the CSQIP as the delivery vehicle for what is a complex program.

(c) The Trust is currently awaiting the draft report from the CQC in relation to their findings, although the CQC has imposed two conditions on the Trust following their visit, requiring the Trust is to provide regular data to the CQC relating to patient outcomes and safety and to commission an external review of cardiac surgery, both of which are in hand.

(d) Whilst progress reports regarding the CSQIP will be brought to BOD and, in more detail, to the Clinical Quality Committee through CQMG, the Chair and Chief Executive have instigated, on a task and finish basis, an oversight group, to be chaired by Catriona McMahon and consisting of Michael Sheppard, Dave Rosser, Philip Norman, David Burbridge, Javid Kayani, Andrea Gordon and Louisa Sorrell. This group will report directly to the Board.

2.2 NICE

2.2.1 The Trust either meets all recommendations, or is working towards meeting all recommendations, in 76% of cases. In 14% of cases, the guidance is under review by a senior clinician. In 8 % 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. At the quarter 1 DCQG the Divisional Directors agreed to 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**	**13**
Division B			
1 Not Compliant 3-Awaiting decision from the Divisional Director followed by CQMG-Email sent.	**0**	**10**	**15**
Division C			
2	**1**	**4**	**30**
Division D			
0	**0**	**6**	**33**

2.2.3 The Trust has recently started to use the NICE monitoring module in 'Health Assure' web-based tool to improve 'live' reporting of compliance. Training has been rolled out to staff who will using the tool and all NICE guidance is currently being updated on the system. Work it currently ongoing with informatics to extract this data into the current risk dashboard.

2.3 Other regulatory requirements

2.3.1 The Risk and Compliance Unit also provides support to the Research and Development department in relation the Medicines and Healthcare products Regulatory Agency (MHRA) / Good Clinical Practice (GCP).

2.3.2 Throughout the trust various specialties have systems in place to monitor compliance against specific regulatory requirements for example MHRA compliance within pharmacy, UK Accreditation Services (UKAS) and Human Tissue Authority compliance within laboratories.

2.3.3 In conjunction with the project manager in R&D and service improvement the Clinical Risk and Compliance team are supporting the programme to ensure all of the Trust's physiology services are IQIPs accredited (Improving Quality In Physiological Services). A number of the standards are similar to those that are required to be compliant with CQC regulations and feedback from service leads who's departments are already IQIPS accredited is that output and the quality of the service has improved as a result.

2.3.4 As advised in the previous Board report during 2015/16 the Senior Manager Clinical Compliance will be liaising with relevant specialties to review their governance arrangements and the outcome of this work will be included in the Q4 report.

3. Trust Compliance with External Visits/Peer Reviews

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.

3.2 Except for the CQC visits see section above the table below contains full details of the outcome of the visits that took place in Q3 2015/16.

Inspecting Organisation	Area being inspected	Date of Visit	Outcome of Visit	Assurance Level
Environment Agency and Counter Terrorism Security	radioactive resources (RRPPS, nuclear medicine)	9 Oct 2015 & 5 Nov 2015	The annual inspection is to ensure compliance with the Permit for sealed radioactive sources. The Trust was fully compliant around the legal requirements and the EA will issue the Trust a new permit, the Counter Terrorism Advisor complemented the Trust as we exceed what they would have expected around physical security measures and the procedures that are in place	Positive
Birmingham Cross City CCG (unannounced)	ED	9 Nov 2015	Purpose of the visit was to look at patient experience, in particular vulnerable patients. No concerns identified	Positive
BSI	RRPPS	10 Nov 2015	The scope of the assessment is the documented management system with relation to the requirements of ISO 9001:2008. There were no non-compliances identified and no action is required	Positive
Endocrinology Peer Review	Endocrinology	23 Nov 2015	Verbal Feedback has been positive but the final report has not been issued.	TBC (Q4 report)

4. Outcome of Audits

4.1 <u>National Audits:</u>

4.1.1 The Trust is currently participating in the majority of the national audits as per the 2015/16 National Clinical Audit and Patient Outcomes. There are a small number of audits which the Trust is not participating in due to the following reasons, which have been agreed by the Medical Director.

4.1.2 Within quarter 3 the following national audit submissions were made:

(a) National Oesophago-Gastric Cancer Audit – Submitted on time. Some issues with data submission and these are being addressed as part of the actions under 4.1.3.

(b) National Bowel Cancer Audit – Submitted on time. Some issues with data submission and these are being addressed as part of the actions under 4.1.3.

(c) National Emergency Laparotomy audit – 83% case submission at time of writing, target is 70%. Final submission deadline 25th Jan 2016. Huge improvement from last year when we had <40%.

(d) National Rheumatology Audit – Due 31st January. 100% submission.

(e) National Parkinson's Audit – Submitted on time. No issues.

(f) Use of blood in lower GI bleeding – Submitted on time. No issues.

4.1.3 The Risk and Compliance Unit have completed a review the national audits and details of the outcome of the review was 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 is based on the model used in Div D.

(b) Implementation of a robust data validation processes

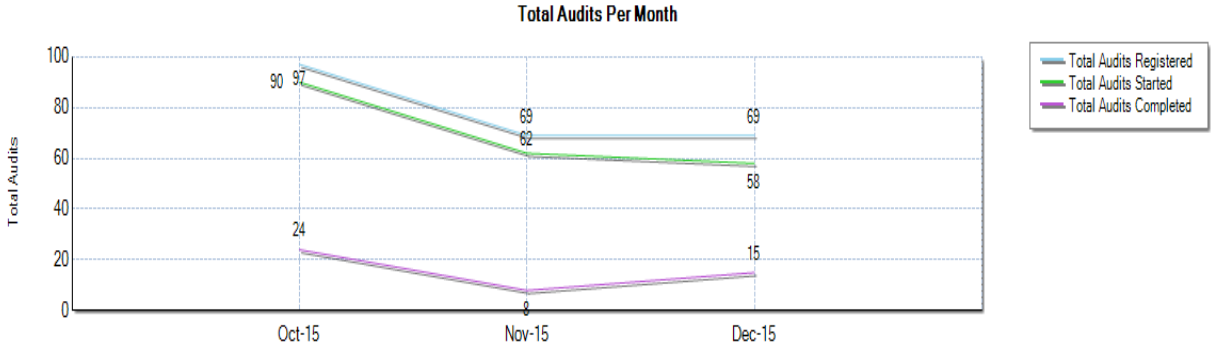
(c) Improved monitoring from risk and compliance including monitoring of actions from national audit reports

(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.

4.2 Local Audits:

4.2.1 The table below provides an overview of the number of local audits registered on the Trusts Clinical Audit Registration & Management System (CARMS) within quarter 3.

Figure 2: Q3 2015/16 total audits registered



5. Risk Register Audit

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

Target	Q1	Q2	Q3	Q4
95%	100%	96.7%	93%	

5.1.2 The reason for the target not being met is due to the number of specialty meetings, where the risk register is reviewed, were cancelled in Division C during quarter 3. The Risk and Compliance Unit have met with the Divisional management team and the Divisional Director and Director of Operations in conjunction with the risk and compliance team will be meeting with those specialties in January 2016 to ensure their risk register is updated and compliance is achieved.

5.1.3 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.

5.1.4 The audit will be repeated for Quarter 4, 2015-16 to ensure continued monitoring of compliance with the risk register process.

6. Recommendation

The Board of Directors is asked to accept this report and agree to receive reports from the CQIP Oversight Group.

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