AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM
NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 25 APRIL 2013

Title:	**COMPLIANCE AND ASSURANCE REPORT**
Responsible Director:	David Burbridge, Director of Corporate Affairs
Contact:	Bob Hibberd, Head of Governance Berit Reglar, Senior Manager Corporate Affairs

Purpose:	To inform the Board of Directors of the Governance and assurance processes and outcomes regarding compliance with the 16 Care Quality Commission Essential Standards of Quality and Safety, 50 NHSLA Risk Management Standards and NICE guidance status.
Confidentiality Level & Reason:	N/A
Annual Plan Ref:	Affects all strategic aims.
Key Issues Summary:	• A robust quarterly assurance process is in place for the core CQC essential standards and NHSLA Risk Management Standards compliance monitoring. • Progress of compliance against CQC and NHSLA Risk Management Standards has been judged to be satisfactory except where stated otherwise. • Evidence for Essential Standards has been judged to be compliant except where stated otherwise. • An action plan is being monitored against identified gaps. • Status of other key indicators
Recommendations:	The Board of Directors is asked to receive the report on compliance with CQC Essential Standards, NHSLA Risk Management Standards, NICE guidance and other key indicators.

Signed:	**Date:** 16 April 2013

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COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY THE DIRECTOR OF CORPORATE AFFAIRS

1. Purpose

This paper presents an overview of compliance against key indicators within the Trust's overall governance arrangements; Governance is leading several streams of work to strengthen the approach to assurance and the processes that support this. This includes:

2. Internal Assurance Process

Due to the significant overlap of the CQC core essential standards with the NHSLA Risk Management Standards, compliance against these standards is monitored by the Governance and Corporate Affairs Team in conjunction. All CQC core standards and NHSLA risk management criteria are assigned to individual manager leads that are responsible for reporting any concerns regarding compliance to the Governance/Corporate Affairs Team.

3. Compliance status

3.1 CQC Essential Standards - CQC Registration Outcomes

3.1.1 During the last quarter, assurance statements have been updated on Health Assure. Designated leads met with the Interim Governance Manager to up date information held in the Health Assure system.

3.1.2 All summaries of evidence have been considered against the outcome standards for completeness. Additional evidence has been added to the database. The retention of all information and evidence in a single database ensures continuity of maintenance and the possibility of producing a position statement at any time.

3.1.3 The database allows attention to be drawn to anything which has changed or needs attention (e.g. a policy needs imminent review or an action plan has been completed) using the part of the report called To Be Noted. This is used in conversation with Directors.

3.1.4 Directors receive a summary email from these conversations and they may then request up dates to the information or confirm that they agree with the current information.

CQC Registration Outcomes

3.1.5 Executive Directors have confirmed compliance status with all standards. However for two Outcomes, the responsible Directors have taken into account work programmes to ensure full assurance regarding compliance, as set out in the following paragraphs.

3.1.6 Outcome 7 Mental Health

The Chief Nurse, chair of the Mental Health Group, has reviewed processes with regard to the Section arrangements of patients with mental health problems. The Trust has processes in place supported by RAID for the review and management of mental health patients; the process for recording the sectioning of patients has been developed and is ready for release following final consultation with stakeholders.

An announced visit by the CQC regarding the application of the mental Health act was undertaken on 27 March 2013. Initial feedback after the visit was positive. The CQC will send a draft report for review and response. The Chief Nurse will await the outcome of the report before considering compliance with Outcome 7.

3.1.7 Outcome 16 WHO checklist

Following the CQC inspection in 2012, the Trust has closely monitored daily compliance rates with the checklist, rates of compliance have improved and are reported through a dashboard on a weekly basis; work is in progress to automate the process to provide daily rates. Governance is undertaking a quarterly quality check of the data.

Evidence has been submitted to the CQC for validation and judgement regarding compliance with the WHO checklist. The CQC is currently planning regulatory activity for 2013/14, which includes follow ups with compliance actions.

3.1.8 Monitoring arrangements are in place through the Governance framework; any failings that are identified and impact on compliance against the CQC standard or any other

regulatory or statutory requirements, will be reported to the appropriate Director and Divisional Management Team. Outcomes 7 and 16 are therefore rated green/amber.

3.1.9 Quality and Risk Profile (QRP) Review

There were no ‘amber’ or ‘red’ risk overall risk estimates for any Outcomes on the QRP during Quarter 4.

3.2 NHSLA Risk Management Standards

3.2.1 NHSLA assessors are attending the trust to evaluate sample evidence for many of the elements of the NHSLA assessment level 2 on April 24th and 25th 2013. The elements where evidence has not previously been seen by assessor will be tested by them.

3.2.2 Elements where we have least confidence are in respect of the evidence for medical personnel (recruitment, induction and registration). Following test assessment in April we will have full clarity on the robustness of this.

3.2.3 The key elements revolve around the Training Needs Analysis and Medical Records. Clear understanding of the ways in which these will be demonstrated in September, at the final assessment, has been identified.

3.2.4 There are 28 elements which we have categorised as Green as a sample of evidence has been seen and accepted as suitable by the assessor at a previous visit or where action(s) suggested by the assessor have been completed. There are 15 items which we have categorised as Amber as the evidence has been checked internally, but has not been seen by the assessor.

3.2.5 The NHSLA assessment is based on a matrix of five columns by ten rows; at level 2 it is necessary to demonstrate that the organisation follows the processes as laid down in relevant policies and procedures. To pass the assessment the Trust must achieve a green in seven of the ten rows in each of the columns; achieving less than seven passes in any column would mean that the assessment is unsuccessful.

3.3 Risk register audit

3.3.1 The findings demonstrate that for the period audited (Quarter 4, 2012/13) there were 65 risk registers on Health Assure and of those 55 (90%) were fully compliant with the risk register process. This shows a decrease in compliance to Quarter 3 2012/13, where out of 65 risk registers, 59 (91%)

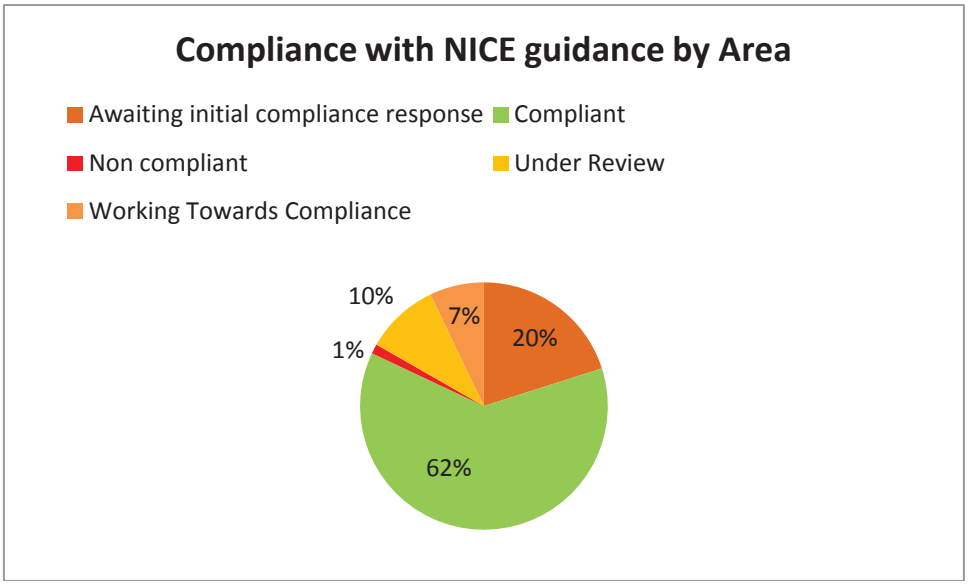
were fully compliant.

3.3.2 The percentage of risk registers that were either compliant or partially compliant, when combined, was 90%. In comparison, in Quarter 3 2012/13, 97% were fully or partially compliant. Therefore the Trust was non-compliant with the criterion for achievement (95%).

3.3.3 An action plan is in place to achieve compliance within the next quarter of activity.

3.4 NICE Guidance Compliance Status

The following chart displays compliance against all NICE Guidance, relevant to the Trust, published since 2000. Compliance is calculated by area acknowledging that NICE recommendations can be applicable to more than one area. The Trust either meets all recommendations, or is working towards meeting all recommendations in 69% of cases, in 30% of cases the guidance is under review by a senior clinician or the Governance team are awaiting a response on compliance status. In 1% of cases there is a divergence (non compliance) against NICE recommendations.



3.5 CAS/NPSA Alert Compliance

Central Alert System (CAS) alerts are monitored through the Trust Datix system, reporting on compliance against the timescales as set out in the individual alerts. There have been no breeches; all alerts were completed within timescale as below.

CAS Quarter 4 compliance rate

No of alerts issued	Assessing relevance	No action required	Action necessary - complete	Action complete within deadline	Action completed beyond deadline
22	7	11	4	4	0

National Patient Safety Agency NPSA /2011/PSA004, safer spinal (intrathecal), epidural and regional devices remains non compliant. Trials of devices are still being undertaken as a result of difficulties in obtaining enough products. The issues have been discussed with the Executive Medical Director A review of NPSA compliance is in with all guidance regarding Pharmacy. All NPSA guidance relating to the Trust is currently being reviewed which commenced in Quarter 4 in line with the process undertaken with NICE guidance to assess ongoing compliance.

3.6 Incident reporting

The Trust measures incident reporting rates per 100 admissions as against the National Reporting and Learning Systems benchmarking. Based on historical data the trust set a benchmark of 7.9 incidents per 100 admissions and has maintained a performance of above KPI since Q1 2010/11. The maintenance of the reporting level has been consistent with the implementation of electronic reporting through the Datix system. This is combined with the development of individual reporting forms for categories of incidents, training in all clinical and departments and the wide reporting and discussion of outcomes from investigations that leads to learning and changes in practice; reflective of an open and learning culture within the organisation.

4 Recommendation

The Board of Directors is asked to receive this report regarding compliance with key indicators.

David Burbridge 16 April 2013
Director of Corporate Affairs

Annex A

Non Compliance

The following divergences against NICE recommendations have been approved by the Divisional Clinical Quality Groups and the Clinical Standards and Audit Group and reported to COOG, where there were no issues raised. Final approval or guidance is needed from the Clinical Quality Monitoring Group before status can be reported to the Clinical Commissioning Group.

NICE ID	Date published	Title	Non compliance	Lead/Committee	Specialty	Division
CG079	Feb-09	Rheumatoid arthritis: the management of rheumatoid arthritis in adults	Approved by Divisional Director - D. The guidance states that people with newly diagnosed active rheumatology are offered a combination of disease modifying drug therapy as first-line treatment as soon as possible, ideally within 3 months of the onset of persistent symptoms. This aspect of the guidance has been debated internally. Other international guidelines including European (pages 4 to 5, http://ard.bmj.com/content/early/2010/05/04/ard.2009.126532.full.pdf) and American guidance (p768 http://www.rheumatology.org/practice/clinical/guidelines/recommendations.pdf) differ from NICE. Therefore the rheumatology department do not routinely recommend combination drug therapy – that is left to the individual clinician in consultation with the patient.	Paresh Jobanputra	Rheumatology	C
CG032	Feb-06	Nutrition support in adults	Approved by the Nutrition Steering Group. The guidance states that manganese levels must be routinely checked every 3-6 months. The practice at UHB is to check manganese levels if it is clinically indicated.	Jane Fletcher	Nutrition Support	B
TA230	Jul-11	Myocardial infarction (persistent ST-segment elevation) - bivalirudin	Approved by the Divisional Director – B. In January 2012 this drug was considered, however more equally clinically effective drugs are currently used instead. An audit undertaken showed current practice for STEMI is acceptable. Non compliance has been placed on the risk register and was approved by the Medicines Management Advisory Group in February 2013.	John Townend	Cardiology	B

The following divergences against NICE recommendations are new, for consideration by CQMG:

NICE ID	Date published	Title	Non compliance	Lead/ Committee	Specialty	Division
CG141	Jun-12	Acute upper GI bleeding	Approved by the Divisional Clinical Quality Group and the Clinical Standards and Audit Group. Routine lists are not provided on Saturdays and Sundays though endoscopy for emergencies is available. The Consultants also do not use Cyanoacrylate. The recommendation relating to routine lists are that: "Units seeing more than 330 cases a year should offer daily endoscopy lists. Units seeing fewer than 330 cases a year should arrange their service according to local circumstances". This will be placed on the GI Medicine Risk Register for continuous review.	Bob Walt	GI Medicine	B
CG100	Jun-11	Alcohol-use disorders: physical complications	Approved by Kay Fawcett, Chief Nurse at a meeting with members of the Mental Health Group to discuss all related mental health NICE guidance. It was agreed that the Trust is non compliant with this piece of guidance because it does not provide symptom triggered alcohol detoxification but as an Acute Trust UHB does follow the West Mercia Guidance and appropriately manages patients according to their clinical need in respect of alcohol use. This will be placed on the Division C Risk Register for review.	Mental Health Group	Mental Health	C /Corporate

The following divergence will be discussed further at the Division A Clinical Quality Group:

NICE ID	Date Published	Title	Non compliance	Lead/Committee	Specialty	Division
CG088	May-09	Low back pain	The guidance states that one of the following options should be used according to patient preference; structured exercise programme, manual therapy or acupuncture. The physiotherapy service at QEHB offer a combination of these treatments and the Specialty have therefore declared themselves non compliant, however guidance does replace clinical judgment and if the clinical judgement is to offer a combination of treatments based on the best interests of the patient this is should be classified as non compliant. This will be raised at the Division A Clinical Quality Group meeting in April 2013. There is also a recommendation that advice and education are included as part of treatment but not all physiotherapy records audited contained evidence that advice and education had been included (CA3-03604-11) a further audit is being undertaken and will be completed by May 2013.	Lynn Lord	Therapy Services	A

ANNEX B

Incident Reporting Rate

The Trust incident reporting rate is calculated against number of patient admissions. The incident rate is an internal indicator and for quarter 4 currently stands at 10.8 incidents per 100 admissions.