UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 27 October 2013

Title:	**COMPLIANCE AND ASSURANCE REPORT**	
Responsible Director:	David Burbridge, Director of Corporate Affairs	
Contact:	Bob Hibberd, Head of Clinical Risk and Compliance Sue Morgan, Interim Head of Corporate Risk and Compliance	
Purpose:	To present an update to 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, NHSLA Risk Management Standards and NICE guidance status.	
Confidentiality Level & Reason:		
Annual Plan Ref:	Affects all strategic aims.	
Key Issues Summary:	• Successful achievement of level 2 assessment against the NHSLA Risk Management Standards • Progress of compliance against CQC has been judged to be satisfactory except where stated otherwise. • Trust now judged to be compliant with WHO checklist by CQC • Evidence for Essential Standards has been judged to be compliant • Action plans where appropriate are being monitored against identified gaps. • Status of other key indicators	
Recommendations:	The Board of Directors is asked to accept the report on compliance with CQC Essential Standards, NHSLA Risk Management Standards, NICE guidance and other key indicators.	
Approved by:	D Burbridge	Date: 16 October 2013

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COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY DIRECTOR OF CORPORATE AFFAIRS

1. Purpose

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

2. Internal/External Assurance Process

2.1 Owing to the significant overlap of the Care Quality Commission (CQC) core essential standards with the NHSLA Risk Management Standards, compliance against these standards is monitored by Clinical and Corporate Risk and Compliance as a combined function. All CQC core standards and NHSLA risk management criteria are assigned to individual manager leads that are responsible for reporting to the Governance/Corporate Affairs Team any concerns regarding compliance

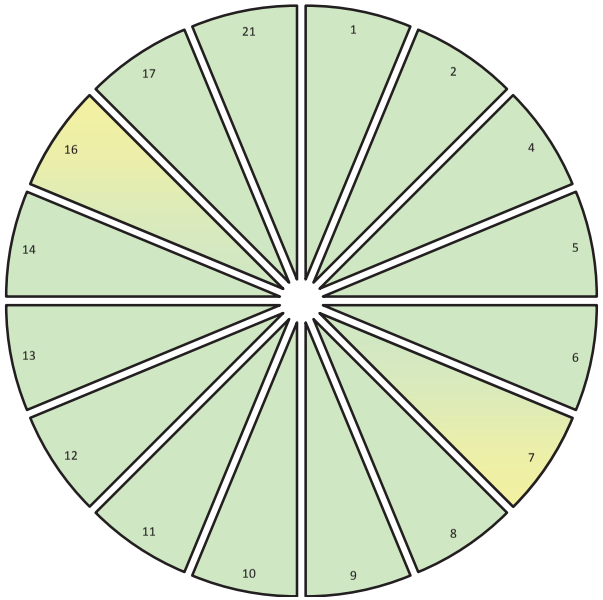
2.2 External Compliance Intelligence

The CQC has published data on trusts measured against indicators as part of the regulators new approach to inspecting acute NHS trusts which will focus on the quality and safety of services based on the things that matter to people. The full impact of this information is being assessed by Risk and Compliance and informatics and in discussion with Executive Directors at Clinical Quality Monitoring Group and will be reported to the Board of Directors in quarter 3.

3. Compliance status

3.1 During the last quarter, assurance statements have been reviewed against evidence within the Governance Framework, incorporating indicators (internal and external), compliance data from the Divisional Clinical Quality Monitoring Groups and outcome standards for completeness. Gaps in a particular outcome are raised with the appropriate lead and fully discussed as part of the quarterly compliance process with Executive Directors.

4. CQC Registration Outcomes



CQC Essential Standards Outcome 16: Assessing and Monitoring the Quality of Service Provision	Amber-Green	• The Trust had a compliance inspection from the CQC on 22-24 July reviewing compliance against this Outcome and Outcomes 4 (Care and Welfare of People Who Use Services), 7 (Safeguarding People Who Use Services from Abuse) and 13 (Staffing). • The final report of the inspection has been received; the Trust is now considered to be compliant with Outcome 16 in relation to the WHO checklist. However during the inspection a further issue was identified in relation to the documentation of patients' food intake and the CQC indicated that they again considered the Trust not to be compliant with Outcome 16. This has been reported as having a 'minor' impact on patients.	Action plan in development, to be reviewed and agreed by Chief Nurse, monitored at Care Quality Group.
CQC Essential Outcome 7: Safe-guarding People Who Use Services from Abuse	Amber-Green	• This standard was inspected by the CQC in July 2013 and was found to be compliant. • Despite this the Trust's Mental Health Group (MHG) has re-reviewed the Trust's evidence against this standard and judged that there are still actions that could be taken to improve the documentation and management of the sectioning of patients under the Mental Health Act. These are improvements have been made within PICS; a planned roll out and education plan will be monitored by the MHG. • A mental capacity assessment an best interests document has been approved by MHG and is available on the intranet	Action plan regarding the CQC inspection is monitored at MHG which reports to the Safeguarding Group.

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5. NHSLA Risk Management Standards

5.1 NHSLA Assessors undertook a formal assessment of the Trust on September 17th and 18th 2013 to assess compliance against the Risk Management standards.

5.2 Formal Assessment outcome

The Trust has been awarded Level 2 by the NHSLA assessors on the 18th September. The Trust was awarded a score of 48/50 for Level 2 which the assessors described a 'phenomenal achievement' for a Trust of this size. The assessors were impressed with the level of competence of all the standard leads. The assessors also appreciated the knowledgeable and positive attitudes of the staff that they met in all areas of the Trust. The assessors have highlighted Medical Devices, Learning & Development and Screening and Diagnostics for their considerable work and sheer effort that had been put into their relevant criteria.

6. Risk Register Audit

6.1 For the period audited (Quarter 2, 2013/14) there were 68 risk registers, an increase of four registers from the last quarter, on Health Assure and of those 47 (69%) were fully compliant with the risk register process. This shows a decrease compared to Quarter 1 2013-14, where out of 64 registers 56 (88%) were fully compliant.

6.2 The report is shared with the divisional management and corporate teams and compliance discussed at DCQG. The audit is repeated for Quarter 3, 2013-14 to ensure a continued monitoring of compliance with the risk register process. The Risk Management Team will liaise with the owners of the risk registers that are not compliant to ensure that compliance is improved .

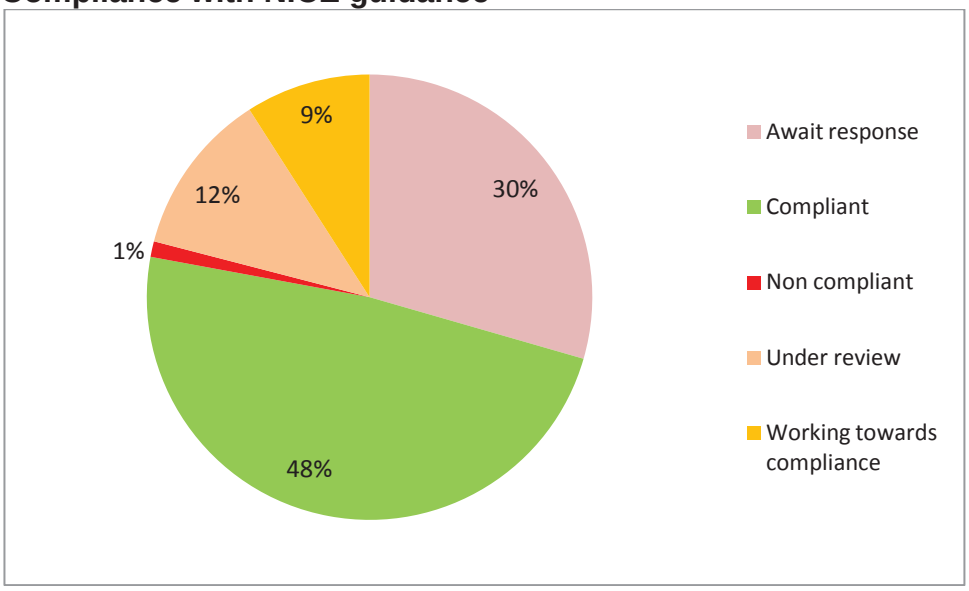
6.3 The percentage of risk registers that were either compliant or partially compliant, when combined, was 97%. In comparison, during Quarter 1 2013-14, 98% were fully or partially compliant. Therefore the Trust was compliant with the criterion for achievement (95%).

7. NICE Guidance

7.1 The following chart displays compliance against 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 57% of cases (Q2 60%), in 30% of cases the guidance is under review by a senior clinician (Q2, 27%). In 1% of cases there is a divergence against NICE recommendations (Q2, 1%).

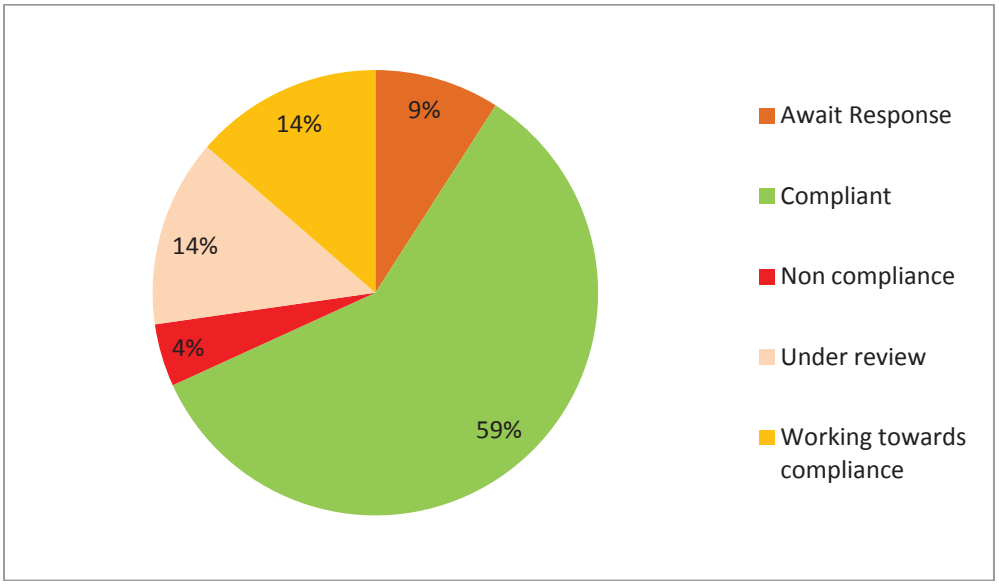
7.2 Compliance is not static and the Risk and Compliance Unit are in regular (at least quarterly) contact with the standard leads where guidance is categorised at working towards compliance or under review, the categorisation of compliance interchanges between under review, working towards compliance and compliance as evidence is received to suggest a chance in status.

Compliance with NICE guidance



7.3 A new process for Technical Appraisals has now been introduced. The Lead Pharmacist - Formulary and Medicines Management tracks all Technical Appraisals, supported by the Risk and Compliance Unit. Exceptions continue to be raised at the Medicine Management Advisory Group and exceptions will be reported to the Clinical Quality Monitoring Group. A review of all technical appraisals pre 2012 is being undertaken.

7.4 The following chart displays compliance with technical appraisals published in the 12 months September 2012 – September 2013. The Trust either meets all recommendations, or is working towards meeting all recommendations in 73% of cases, in 14% of cases the guidance is under review by a senior clinician. There is 1 case of non compliance which needs to be discussed further with the Division before approval is sought from CQMG. The Trust is contracted to meet technical appraisals within 3 months of issue and the risk and compliance team are to discuss the implications of not meeting these recommendations with the contract team.



7.5 NICE Quality Standards

There are 43 NICE Quality Standards applicable to UHB. 48 have been published in total and 5 are not applicable. 31 have been reviewed so far. The status of each is described in the chart below. 304 standards have been reviewed with approximately 1000 indicators applicable to UHB.

The next stage, for those that been reviewed for applicability, is to review each indicator considered as applicable and important to measure. The indicators will be discussed with the Head of Quality Development, Deputy Head of Clinical Risk and Compliance and the Clinical Intelligence Analyst to progress further via QuORU. It is hoped that the quarter 3 report will contain specific information on the number of applicable measures, the indicators, or proxy indicators in place and performance. Indicators not considered measurable at this time, or not considered valid will be linked to the relevant piece of NICE guidance assurance.

8. Audit Compliance

Risk and Compliance monitor audit activity within the Trust in various elements.

8.1 NCAPOP audits

UHB is currently **not fully** participating in National Vascular Database audits. The Division continue to concentrate on fully participating in the Aneurysm and Carotid audit. A phased plan for participation in all audits (including the two other mandatory audits lower limb bypass and amputation) is being planned.

8.2 Quality Account audits

UHB is not participating in National Cardiac Arrest Audit. There is no planned update to the national system to allow data to be imported from the Trust database which is more comprehensive than the national audit database. This was reviewed again by the Associate Medical Director for Clinical Standards and Governance and agreed by the Clinical Quality Monitoring Group in May 2013.

8.3 NCEPOD

A full review of all recommendations classified as working towards compliance continues to be undertaken; gaps in practice identified so far are listed below. A review of NCEPOD processes and reporting continues to ensure recommendations are aligned with NICE processes to achieve consistency of detail in reporting, this should be completed by December 2013. A review of recommendations categorised as working towards compliance or under review has been partially completed in quarter 2. There are 283 recommendations relevant to the Trust in total, 181 are complaint, 27 recommendations are being discussed in relation to Alcohol Liver Disease, the latest publication.

9. CAS/NPSA Alert Compliance

9.1 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.

9.2 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. An update paper on the status of working towards compliance was detailed in the update paper for the Chief Executive's Advisory Group in February 2014.

10. Recommendation

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