UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 24 JULY 2014

Title:	**COMPLIANCE AND ASSURANCE REPORT**	
Responsible Director:	David Burbridge, Director of Corporate Affairs	
Contact:	Sarah Favell, Associate Director of Corporate Affairs, Legal and Risk Bob Hibberd, Head of Clinical Risk and 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 15 of the 16 CQC Essential Standards. • The Trust is CQC risk rated at Band 2 of 6, with 1 being worst and 6 being the best (Q4, Band 4). • The percentage of risk registers that were either compliant or partially compliant, when combined, was 99%. • Substantial assurance received from the Board Assurance Framework internal audit.	
Recommendations:	The Board of Directors is asked to accept the report.	
Approved by:	D Burbridge	Date: July 2014

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COMPLIANCE AND ASSURANCE REPORT

PRESENTED BY DIRECTOR OF CORPORATE AFFAIRS

1. Purpose

This paper presents internal and external compliance.

2. Internal Assurance

2.1 CQC Essential Standards of Quality and Safety

The Trust has a process in place to ensure assurance against the Essential Standards. Table 1 below is an overview of the Trust position on Outcome 16, this remains the same as Quarter 3 13-14. External assessment is the rating given to the Trust by the CQC and the internal assessment is the rating against the outcomes based on internal assurance provided as part of the Governance Framework. 15 of the 16 outcomes are compliant.

Outcome	Internal Assessment	CQC External Assessment	Explanation	Assurance
CQC Essential Standards Outcome 16: Assessing and Monitoring the Quality of Service Provision	Amber-Green	Non compliant – minor improvements	**Date of inspection:** 22-24 July 2013 **Review of Outcomes:** 16(Assessing and Monitoring the Quality of Service Provision) 4 (Care and Welfare of People Who Use Services) 7 (Safeguarding People Who Use Services from Abuse) 13 (Staffing). **Compliance:** Not compliant with Outcome 16. An issue was identified in relation to the documentation of patient's food intake. **Impact:** Minor	Actions in place reviewed and agreed by Chief Nurse, monitored at Care Quality Group. An adapted audit tool for the assessment of patients who require assistance whilst feeding has been developed which will provide better assurance.

The annual audit for safe and secure medicine is currently being undertaken; initial findings show that changes in the management of medicines is required. The Chief Nurse has developed an action plan to mitigate any risks that the audit may show. The issues have been discussed at Safe Medicines Practice. The risks have been added to the Medical Director and Chief Nurse risk register.

2.2 Risk Register Audit

The Trust has a process in place to ensure that risk registers are reviewed and compliance (risk registers compliant or partially compliant) reported on a quarterly basis.

Target	Q4	Q1
95%	99%	99%

2.3 NICE Guidance

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

The Trust either meets all recommendations, or is working towards meeting all recommendations in 67% of cases, in 9% of cases the guidance is under review by a senior clinician. In 1% of cases there is a divergence against NICE recommendations. In 22% of cases the Risk and Compliance Unit are awaiting a response from the Guidance Lead. Overdue responses will be escalated to the Specialty Board and are escalated to the Divisional Clinical Quality Group and / or the Clinical Standards Audit Group.

The Trust has purchased NICE Guidance, NICE Quality Standards and NCEPOD assurance software from Allocate Software. This will allow an element of automation of the process saving administrative time, will enable a triangulation of compliance reporting and allow work to progress on a Risk and Compliance Dashboard for key groups and committees with the Governance Framework. The new software will be implemented within Q2 2014/15 at the same time as the completion of the full review of assurance against compliant guidance.

2.4 National Audit

During 2013/14 UHB participated in 90% of the national clinical audits it was eligible to participate in. These have been approved by the Medical Director via the Clinical Quality Monitoring Group.

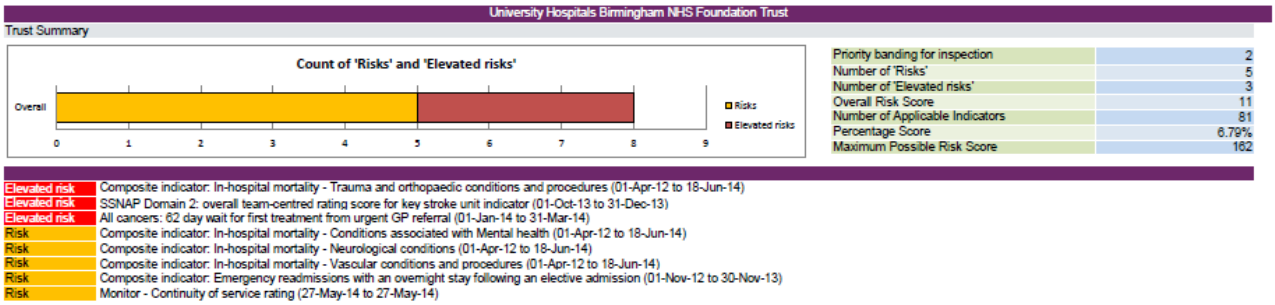
2.5 Internal Audit

KPMG undertook an internal audit of the processes for the Board Assurance Framework (BAF) and reported an assurance level of significant.

3. External Assurance

3.1 CQC Intelligence Monitoring Data

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 is placed in Band 2 of 6 with 1 being the worst and 6 being the best (Q4, Band 4).



The Trust has written to the CQC challenging the use and construction of the present system on the basis that it is not, in its entirety, a suitable or effective tool for doing so, because, amongst other things:

a) It weights all 81 indicators equally, having no regard to, say, the number of patients covered by a particular mortality indicator;

b) It is overly sensitive. A very low score is required to put a trust into a high risk band, particularly when the denominator is reduced by the exclusion of indicators not relevant to a trust. Additionally, this Trust has gone from Band 3 to 4 and now to 2 over the last three quarters, when, to my knowledge, little has actually changed at the Trust;

c) It includes inappropriate indicators, for example, some of which take no account of the differences between different types of hospitals and others where the "performance" of the trust is affected by the actions/inactions of others; and

d) It includes indicators which rely on historical data.

Please note the following with regard to the specific indicators for which the Trust has been scored as Elevated Risk or Risk.

Composite indicator: In-hospital mortality – trauma and orthopaedic conditions and procedures (01 Apr 12 to 18-Jun-14) (Elevated Risk)

Composite Indicator: In-hospital mortality – conditions associated with mental health (Risk)

Composite Indicator: In-hospital mortality – Neurological conditions (01-Apr-12 to 18-Jun-14) (Risk)

Composite Indicator: In-hospital mortality – Vascular conditions and procedures (01-Apr-12 to 18-Jun-14) (Risk)

The Trust has internally replicated the CQC methodology and we have not disputed the outputs of these indicators adopted by the CQC. However, it is considered that the methodology underlying these indicators is flawed and therefore, these indicators are not appropriate for use as indicators of risk. The methodology looks at age, gender, and primary diagnosis and does not take into account the full extent of what is wrong with the patients nor does it take into consideration any underlying conditions the patients may have that impact on patients' outcomes. Underlying conditions are a key issue for patients referred to UHB as a tertiary centre. For example, the In-hospital mortality – trauma and orthopaedic conditions and procedures indicator does not adjust for the fact that

UHB is a major trauma centre. In common with other major trauma centres, we have seen an increase in the number of complex and serious increases, against a corresponding decrease of such cases in neighbouring hospitals.

SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (01-Oct-13 to 31-Dec-13) (Elevated Risk)

The Trust's scores for this indicator are not disputed. However, the indicator is not representative because, in many cases rehabilitation is off-site and therefore not included within the calculation, even though patients spend 90% of their time on the Stroke Unit overall. Further, the dataset is over 6 months old. The compliance against this target has been improving steadily since January 2014 despite an increase in activity due in part to additional referrals following closure of the stroke unit in Redditch and the decision (of which we had no prior warning) by City and Sandwell to move its stroke unit. Improvements in and expansion of the Stroke Pathway are underway, an additional stroke consultant has been appointed, the ward expanded by 8 beds and the appointment of 2 stroke nurse practitioners.

All cancers: 62 day wait for first treatment from urgent GP referral (01-Jan14 to 31-Mar-14) (Elevated Risk)

As the Board is aware, the Tust has experienced, and continues to experience, an increase in referrals across all tumour sites. Following investigation, many of these are found to be non-malignant and also clinically many are felt to be inappropriate referrals. Late referrals (after day 41 on the 62 day pathway) into UHB are a significant challenge with regards to meeting the 62 day standard. For the period (01-Jan14 to 31-Mar-14) 32 of the reported breaches were received after day 41. These are all reported to Commissioners. In April 2014, the Trust received a significant number of late tertiary referrals, with 11 tertiary referrals received after day 42 of the pathway. Of these, 5 were received after day 62 and it was therefore impossible to treat these patients within the target. Performance for those pathways wholly relating to UHB was 89.7% in April, an increase from 80.4% in March.

Composite indicator: Emergency readmissions with an overnight stay following an elective admission (01-Nov-12 to 30-Nov-13) (Risk)

The Trust has accepted the accuracy of the figures provided for Emergency readmissions with an overnight stay following an elective admission. However, there are concerns regarding the methodology used to calculate the indicator.

The specialties with the highest Standardised readmission ratio (SRR) are Gastroenterology and Hepatology, Cardiac-related conditions and Nephrology conditions. At UHB, these specialties will treat patients who are either on a transplant waiting list or had a transplant and therefore appropriate comparison with other providers who provide these services would be more appropriate. The complexity of these patients and the nature of the circumstances they are involved in will not be experienced at many other providers and standardisation of age, sex, primary diagnosis at admission and Charlson Index will not sufficiently account for the elevated clinical risk.

The nature of the readmission is for any cause and not those associated with the

original readmission.

Monitor – continuity of service rating (27-May-14 to 27-May-14) (Risk)

It is not considered appropriate for the Monitor CoSRR to be used as an indicator of current risk of poor care. It is used by Monitor to assess the risk of a trust being unable to provide services in future due to its financial position. The Board is aware of the detailed discussions with Monitor regarding how this indicator is biased against trusts with a major PFI project.

Even if it were appropriate to be used as a risk indicator by the CQC, a Trust with a 2* rating should not be scored the same as a trust with a 2 rating. Monitor's own risk assessment framework makes it clear that a FT with a 2* rating does not attract any greater regulatory action than one with a rating of 3 – see extracted diagram below.

Continuity of services risk rating[1]	Description	Monitoring frequency	Regulatory activity
4	No evident concerns	Quarterly	None
3	Emerging or minor concern potentially requiring scrutiny	Potential monthly	None
2*	Level of risk is material but stable	Potential monthly	None
2	Material risk	Monthly or greater	Consideration for potential investigation (see Chapter 5)
1	Significant risk	Monthly or greater	Potential investigation (see Chapter 5) Potential appointment of contingency planning team

[1] Weighted average, *rounded up*, across the two components of the continuity of services risk rating.

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 1 the Risk and Compliance Unit were notified of 3 visits by external organisations with 2 action plans outstanding and 1 action outstanding for 1 visit. Actions are monitored by the Director of Corporate Affairs Governance Group.

4. **Department of Health (DH) consultation to replace the Essential Standards with Fundamental Standards**

The Trust responded to the consultation by the DH on the new regulations to replace the Essential Standards with Fundamental Standards, as recommended by Francis. In particular, the Trust advised that offences subject to prosecution are still broad enough for different interpretation and judgement. If there are to be criminal sanctions, it is essential that the requirements for compliance are clear and not subject to subjective interpretation. There must be consideration of the importance of clinical opinion in choosing to diverge from 'generally accepted professional standards' depending on the circumstances and in partnership with the patient, also consideration of the patient right of refusal to treatment if they are deemed to have capacity or their best interests in the absence of capacity.

5. **Response to Francis/Keogh/Berwick recommendations**

The Trust has linked the recommendations deriving from the Francis/Keogh/Berwick Reports to the Trust Quality Account priorities and collects any associated evidence/assurances as part of the Governance Framework.

6. **Provider Licence**

The Trust has completed its assurance process in relation to Monitor's Provider Licence. Where possible, requirements have been linked to the Governance Framework. In order to be fully compliant with the new 'fit and proper person test', which will be introduced in October 2014, subject to Parliamentary approval, the following actions will be undertaken:

- Minor modifications to the Code of Conduct for Directors and Governors
- Minor amendment to the Constitution to allow for the automatic disqualification of directors who do not meet the test
- (Re-)draft of employment contracts/engagement letters of Executive Directors/NEDs

The Trust is already compliant with all other requirements.

7. **Recommendation**

The Board of Directors are asked to accept this report.

David Burbridge
Director of Corporate Affairs